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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

12635  
12585  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Whiteford</b>		c. LENGTH OF STAY IN 1b <b>11 yrs.</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Whiteford</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS <b>R.D. #1</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Enos Baird Anderson</b>				4. DATE OF DEATH <b>November 4 1960</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 26, 1893</b>	9. AGE (In years last birthday) <b>67</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MILLWORKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>STEEL</b>		11. BIRTHPLACE (State or foreign country) <b>McMECHEN, W.VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ENOS ANDERSON</b>				14. MOTHER'S MAIDEN NAME <b>ANNA BARTHOLEMEN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, if not unknown) <b>No</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-07-8143</b>		17. INFORMANT <b>CLARA ANDERSON, WHITEFORD, MD.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Gerald C Palmer</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> <b>Bel Air, Md.</b>			
EXAMINER'S NAME (Type) <b>Gerald C Palmer, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>11-5-60</b>			
22a. BURIAL, CREMATION, or other disposal (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>11-7-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>TABERNACLE</b>	
22d. LOCATION (City, town, or country) <b>WHITEFORD, MD.</b>				22e. (State)			
23. FUNERAL DIRECTOR <b>John H. Halima, DELTA, PA.</b> ADDRESS				24a. REC'D BY REGISTRAR <b>NOV 9 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hirsch</b>	

WILEY-INTERSCIENCE, JOHN WILEY & SONS, INC.

12616

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford Maryland</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford</i>	
c. LENGTH OF STAY IN 1b <i>78 yrs.</i>		d. STREET ADDRESS <i>114 McPherson Ave.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Nellie Boyd Backus</i>		4. DATE OF DEATH <i>11/26/60</i> 19 <i>60</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/6/1882</i>
9. AGE (in years last birthday) <i>78</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>Harford</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George G. Boyd</i>		14. MOTHER'S MAIDEN NAME <i>Rose Lawder</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>Mr. Melvin Gordon Harford</i>		Address <i>114 McPherson Ave.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Decomposition</i> 443X DUE TO <i>arterio sclerotic cardiovascular disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertension</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office Bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 11-26, 1960</i> to <i>Nov 26, 1960</i> that I last saw the deceased alive on <i>11-26, 1960</i> and that death occurred at <i>8 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Edna Simon</i>		ADDRESS (Street, city or town, state) <i>Harford Md.</i>	
PHYSICIAN'S NAME (Type) <i>E. J. SIMON</i>		DATE SIGNED <i>Nov 26, 1960</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Harford Md.</i>		22b. DATE THEREOF <i>11/29/60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Angel Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Harford Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James M. Harford</i>		ADDRESS <i>Harford Md.</i>	
24a. REC'D BY REGISTRAR <i>DEC 5 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Harford</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1912

NEW YORK STATE DEPARTMENT OF HEALTH

Blank certificate form with horizontal lines for text entry.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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12636

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12587

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Bel-air</i>		c. LENGTH OF STAY IN 1b <i>Lifetime</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Bel-air, md</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Box 286 Route 1 Bel-air md</i>				d. STREET ADDRESS <i>Box 286 Route 1 Bel-air</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>John</i> Middle <i>-</i> Last <i>Barnes</i>				4. DATE OF DEATH Month <i>11</i> Day <i>28</i> Year <i>1960</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>February 28, 1882</i>		9. AGE (In years last birthday) <i>78</i> yrs.	IF UNDER 1 YEAR Months <i>9</i> Days <i>x</i> Hours <i>x</i> Min. <i>x</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Stone Quarry</i>		11. BIRTHPLACE (State or foreign country) <i>Harford County, md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>No record</i>				14. MOTHER'S MAIDEN NAME <i>Emma Barnes</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>214-16-6986</i>		17. INFORMANT <i>Mrs Mary E. Barnes</i> Address <i>Box 286, Route 1 Bel-air, Maryland</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>LOBAR PNEUMONIA</i> <i>490X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <i>5 DAYS</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>SILICOSIS</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month. Day. Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <i>6/8/1953</i> to <i>11/28</i> 19 <i>60</i> that (I) (we) last saw the deceased alive on <i>11/28</i> 19 <i>60</i> and that death occurred at <i>11:28</i> P. M. from the causes and on the date stated above.			
22a. SIGNATURE <i>Robert Barthel</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>11/30/60</i>		22c. PHYSICIAN'S NAME (Type) <i>ROBERT BARTHEL</i>	
22d. ADDRESS <i>Forest Hill, md</i>		23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>					
23b. DATE THEREOF <i>12/2/60</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Clark's Chapel Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Harford County md</i>		24. FUNERAL DIRECTOR'S SIGNATURE <i>Elmer E. Bullen</i>	
24b. ADDRESS <i>Harford County, md</i>		25a. REC'D BY REGISTRAR <i>DEC 6 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Hanna</i>		25c. DATE <i>DEC 6 '60</i>	



*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*

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THE CHURCH OF ENGLAND

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12611

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12588

1. PLACE OF DEATH a. COUNTY <u>Hanford</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bellaire</u> c. LENGTH OF STAY IN 1b <u>1 month</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hanford Convalescing Home</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hanford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u> d. STREET ADDRESS <u>Andrews Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Theresa R. Binder</u> First <u>R.</u> Middle <u>B.</u> Last <u>Binder</u>		4. DATE OF DEATH <u>November 25 19 60</u> Month <u>November</u> Day <u>25</u> Year <u>19 60</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-11-81</u> 9. AGE (In years last birthday) <u>79</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Unknown</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Unknown</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>B20 01 1568</u>		17. INFORMANT <u>Robt. T. Binder, Aberdeen, Md.</u> Address <u>634 Andrews Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV disease</u> <u>422.01</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ (a), stating the underlying cause lost. _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) _____			INTERVAL BETWEEN ONSET AND DEATH _____
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>attended from 10-19-60 to 11-25-60</u>	20f. (City or town) (County) (State) _____
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C. Palmer</u> EXAMINER'S NAME (Type) <u>Gerald C. Palmer, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>11/26/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Irving Pk. Blvd Cem. of Ill. Chicago, Ill.</u>	22d. LOCATION (City, town, or county) (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tarring Funeral Home</u> ADDRESS <u>Aberdeen, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 30 1960</u>	24b. REGISTRAR'S SIGNATURE _____

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please write the cause of death, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records or removal.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12612

## CERTIFICATE OF DEATH

Reg. Dist. No.

12589

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bel Air</i>		c. LENGTH OF STAY IN 1b <i>Lifetime</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>East Broadway</i>		e. STREET ADDRESS <i>1 East Broadway</i>	
3. NAME OF DECEASED (Type or print) First <i>BESSIE</i> Middle <i>BOARMAN</i> Last <i>BOARMAN</i>		4. DATE OF DEATH Month <i>NOVEMBER</i> Day <i>27</i> Year <i>1960</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>August 7, 1875</i>
9. AGE (In years last birthday) <i>85</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Merchiant</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Hardware</i>	
11. BIRTHPLACE (State or foreign country) <i>Harford County, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>BENJAMIN F. BOARMAN</i>		14. MOTHER'S MAIDEN NAME <i>FRANCES E. HOLLAND</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Herace Boorman</i>		Address <i>455 Choice Street, Bel Air, Maryland</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>—</i> DUE TO (c) <i>—</i> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Nov. 27</i> , 19 <i>56</i> , to <i>Nov. 27</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>Nov. 27</i> , 19 <i>60</i> , and that death occurred at <i>1:30 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>126 S. Main Bel Air</i> DATE SIGNED <i>11/25/60</i> ACTUAL SIGNATURE <i>Charles Richardson</i> PHYSICIAN'S NAME (Type) <i>Joseph W. Foster</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Nov. 29, 1960</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Rock Spring Episcopal Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Forest Hill, Harford Co., Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph W. Foster</i>		24a. REC'D BY REGISTRAR ADDRESS <i>W. Broadway + Will. Ams St. Bel Air, Maryland</i> DATE <i>NOV 29 '60</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Brown</i>			

CERTIFICATE OF DEATH

1915

*[Faint, mostly illegible handwritten text on a death certificate form. The form includes sections for patient information, cause of death, and medical history.]*

LOUISIANA DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
NEW ORLEANS, LOUISIANA

## CERTIFICATE OF DEATH

Reg. Dist. No.

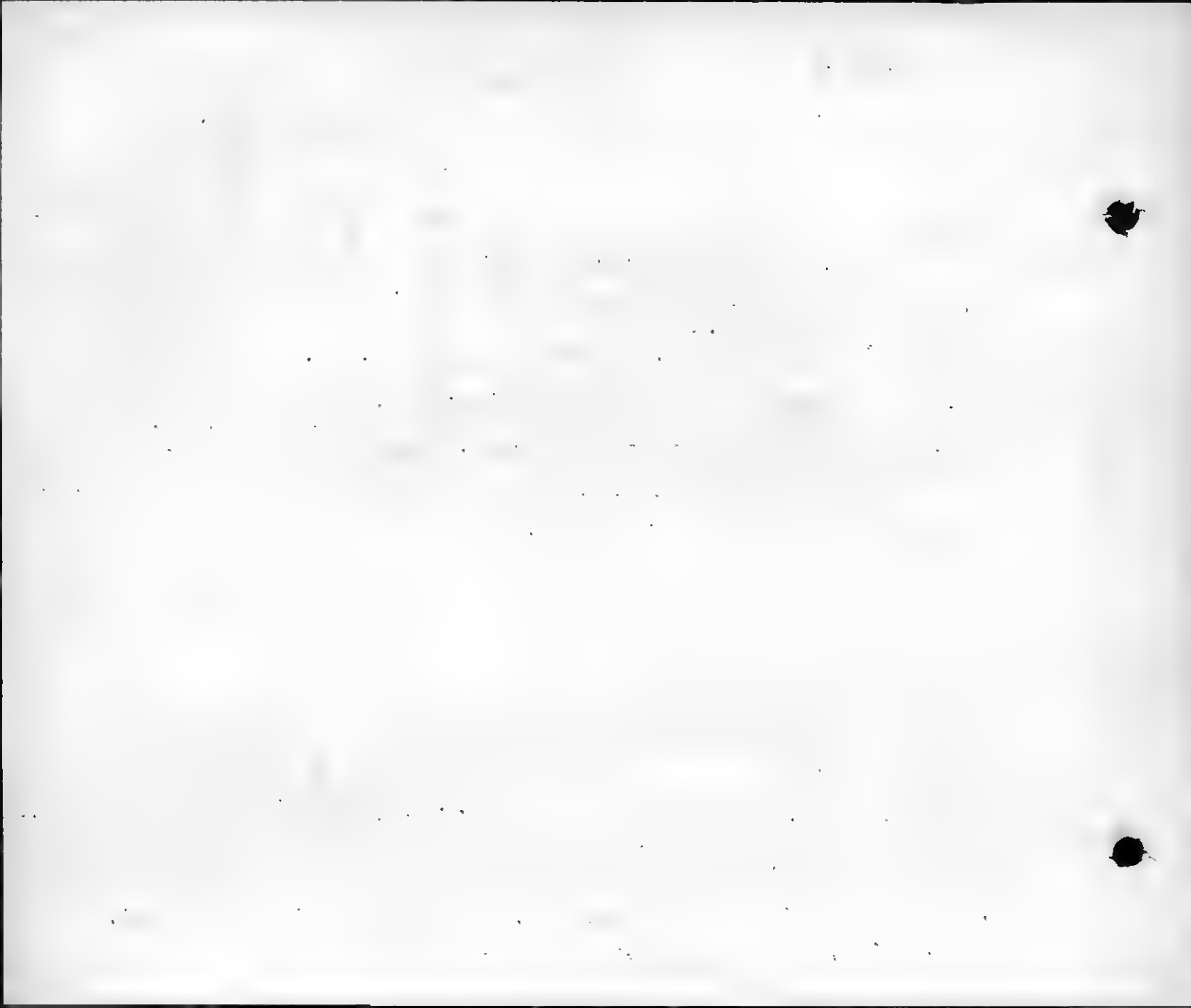
12590

12613

1. PLACE OF DEATH a. COUNTY <b>Harford</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Res dence before adm ssion) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bel Air</b>		c. LENGTH OF STAY IN 1b <b>1 month</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>154 North Main Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Roy</b> Middle <b>Jirdon</b> Last <b>Boggs</b>		4. DATE OF DEATH Month <b>Nov</b> Day <b>29</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-5-1901</b>
9. AGE (In years last birthday) <b>57</b> yrs.		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>2</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm employee</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gen. Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Renick, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Andrew Boggs</b>		14. MOTHER'S MAIDEN NAME <b>Nettie M. Simmons</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>183-18-6555</b>	
17. INFORMANT <b>Dane B. Boggs</b>		18. ADDRESS <b>MacPhail, Rd. Bel Air, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIO-RESPIRATORY FAILURE</b> 200.1 DUE TO <b>LYMPHOC SARCOMA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>20 HRS</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a m p m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office b dg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5:45</b> 19 <b>45</b> to <b>2:30</b> 19 <b>60</b> , that I last saw the deceased alive on <b>2-25-60</b> , and that death occurred at <b>2:15</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>H. P. Stowell</b>		DATE SIGNED <b>Nov 29 1960</b>	
PHYSICIAN'S NAME (Type) <b>H. P. Stowell M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/28/1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Mem. Gardens</b>	22d. LOCATION (City, town, or county) (State) <b>Bel Air, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Futz</b>		24a. REC'D BY REGISTRAR <b>Nov 29 '60</b>	
ADDRESS <b>Farmersville Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Futz</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPENDENT: This certificate should be executed within 24 hours after death. If any delay is necessary, please forward the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12637 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Harford</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Del Penna</u> b. COUNTY <u>Harford</u>				c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Woodbine</u>			
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Whiteford</u>				c. LENGTH OF STAY IN 1b				d. STREET ADDRESS <u>R.D.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Line Bridge Road</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>A. Everett Boothe</u>				4. DATE OF DEATH <u>November 29 1960</u>							
5. SEX <u>M</u>				6. COLOR OR RACE <u>W</u>				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>			
8. DATE OF BIRTH <u>Apr. 11, 1939</u>				9. AGE (In years last birthday) <u>21</u> yrs.				10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours M n.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Delta, Pa.</u>				11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>George Boothe</u>				14. MOTHER'S MAIDEN NAME <u>Doris Ridd</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>207-30-5261</u>				17. INFORMANT <u>George Boothe, Woodbine, R.D., Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull</u> 912-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Tractor fell on him</u>							
20c. TIME OF INJURY Month, Day, Year <u>3 11-29 1960</u>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Line Bridge Rd. Farm 4TH Harford Whiteford Hg. Md.</u>			
20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Lowell C Palmer</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Lowell C Palmer</u>				Address (Street, city, town, or county) <u>11-30-60</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Dec. 3, 1960</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Union Chapel</u>			
22d. LOCATION (City, town, or county) (State) <u>Summerville, Pa.</u>											
23. FUNERAL DIRECTOR <u>John H. Harbison, Delta, Pa.</u>				ADDRESS				24a. REC'D BY REGISTRAR <u>DADEC 2 '60</u>			
								24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>			





1

12617

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

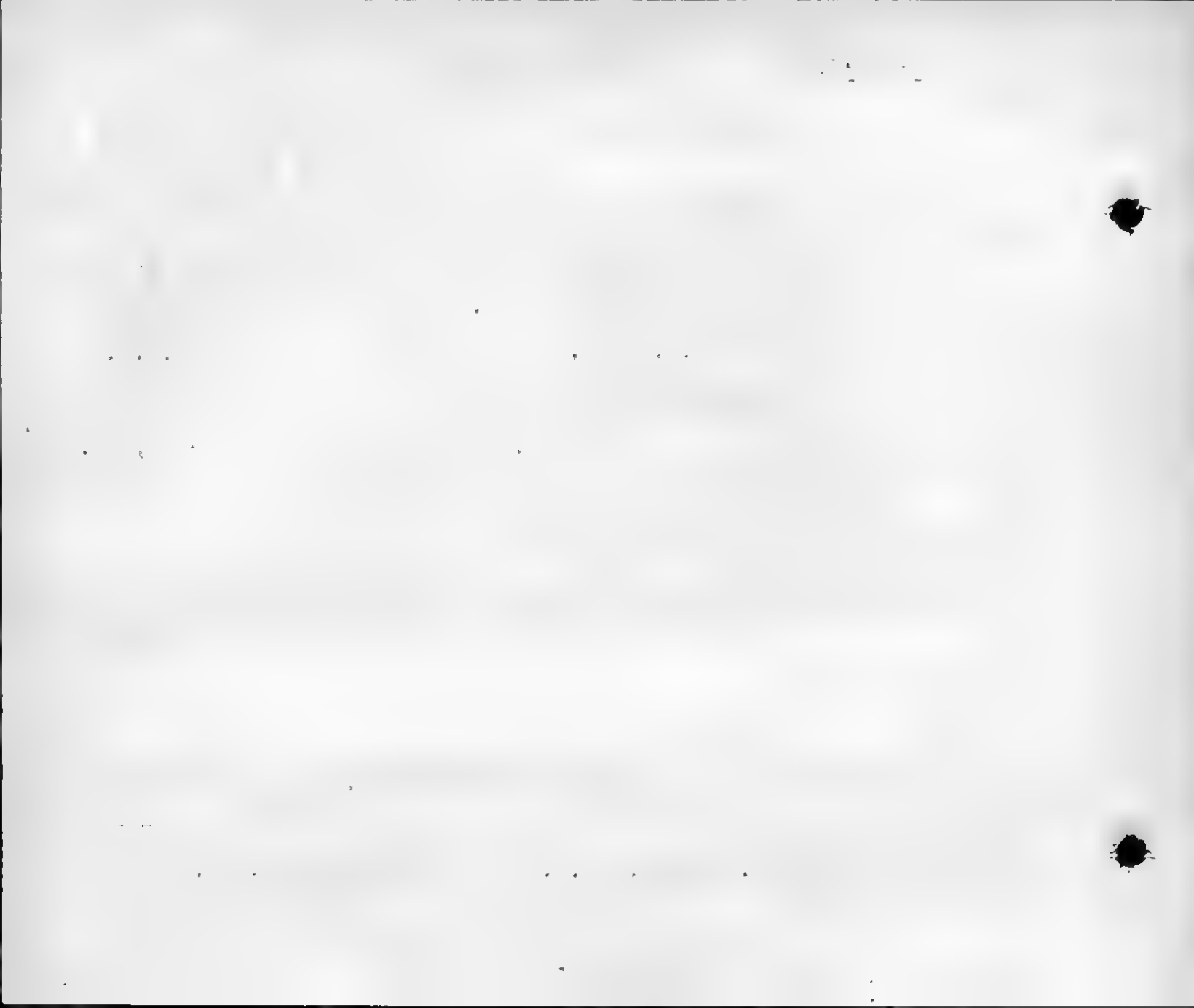
12592

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Harford</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>		c. LENGTH OF STAY IN 1b <b>2 1/2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>305 Wilson Street</b>		d. STREET ADDRESS <b>305 Wilson Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>FRANCIS</b> Last <b>BULL</b>		4. DATE OF DEATH Month <b>November</b> Day <b>1</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 18, 1879</b>
9. AGE (In years last birthday) yrs <b>81</b>		IF UNDER 1 YEAR Months <b>1</b> Days <b>19</b> Hours <b>60</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Govt.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Franklin Francis Bull</b>		14. MOTHER'S MAIDEN NAME <b>Sophia Elliott</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>331X</b>	
17. INFORMANT <b>Mrs. Lula Bull, Havre de Grace, Md.</b>		Address <b>305 Wilson St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CEREBRO-VASCULAR ACCIDENT</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>ARTERIO SCLEROSIS</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>19 56</b> , to <b>Nov. 1</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Oct. 25</b> , 19 <b>60</b> , and that death occurred at <b>6:10 AM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>421 Congress Ave.</b> DATE SIGNED <b>11-3-60</b>			
ACTUAL SIGNATURE <b>Gunther D. Hirsch</b> M.D.		DATE SIGNED <b>11-3-60</b>	
PHYSICIAN'S NAME (Type) <b>Gunther D. Hirsch, M.D.</b>		<b>Havre de Grace, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/4/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Grove Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Aberdeen, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Tarring</b>		24a. REC'D BY REGISTRAR <b>NOV 7 '60</b>	24b. REGISTRAR'S SIGNATURE <b>William S. Kline</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

12593

Reg. Dist. No.

12618

1 PLACE OF DEATH a. COUNTY <u>Harford Maryland</u>		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1120 S. Washington</u>	
3. NAME OF DECEASED (Type or print) <u>Helen J. Burns</u>		4. DATE OF DEATH <u>11/6/60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/18/1881</u>
9. AGE (In years last birthday) <u>79</u>		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford Chase, Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Orlo Susan</u>		14. MOTHER'S MAIDEN NAME <u>Helen Bailey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>Unknown</u>	
17. INFORMANT <u>Mrs. Louise Waller</u>		Address <u>1120 S. Washington Harford Chase, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiac</u> 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Chronic Arteriosclerosis - nephritis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/15</u> 19 <u>32</u> to <u>11/6</u> 19 <u>60</u> , that I last saw the deceased alive on <u>11-6</u> 19 <u>60</u> , and that death occurred at <u>8 A.</u> M., from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>11/19/60</u> DATE SIGNED			
ACTUAL SIGNATURE <u>[Signature]</u>			
PHYSICIAN'S NAME (Type) <u>[Signature]</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>11/9/60</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Harford Chase, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Harford Chase, Md.</u>	
24a. RECEIVED BY REGISTRAR <u>NOV 9 '60</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





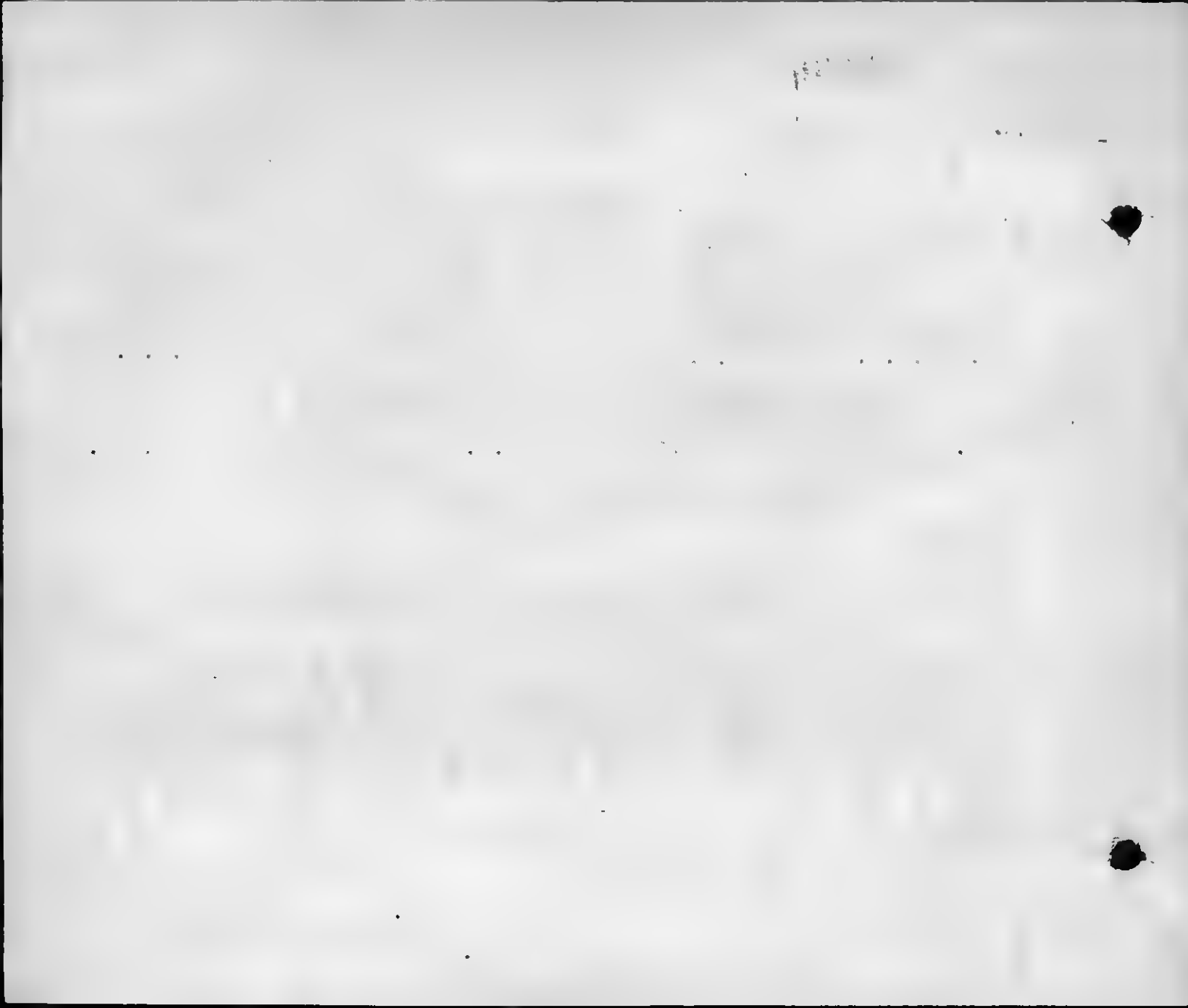
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, it should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
FOR STATE  
HEALTH DEPT.

(M)

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if last institution; Residence before admission)			
a. COUNTY				e. STATE			
Harford				Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b			
Harford							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
Harford Memorial Hospital				1225 Rush St			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
Patricia A. Conboy				November 13 1960			
5. SEX				6. COLOR OR RACE			
Female				White			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>				8. DATE OF BIRTH			
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				April 14, 1941			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
S.A.U.S.N.				U.S. Navy			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Herman Oscar Conboy				Agatha Lorraine Pike			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)				16. SOCIAL SECURITY NO.			
Yes, Feb. 1960-Nov. 1960				59-54-0650			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				19. WAS AUTOPSY PERFORMED?			
PART I. DEATH WAS CAUSED BY:				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) Fracture cervical vertebra							
812X DUE TO							
Conditions, if any, which gave rise to immediate cause (b)							
(c) DUE TO							
cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
				Auto accident auto pedestrian type			
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED			
Hour 11:13 p.m. 11-13-60				While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
				20f. (City or town) (County) (State)			
				Port Deposit Cecil Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from							
Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
Lorrell C Palmer				DATE SIGNED			
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Gerald C Palmer MD				11-13-60			
22a. BURIAL, CREMATION, REMOVAL, etc.				22b. DATE THEREOF			
Burial				11-13-1960			
22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or country) (State)			
Greenwood Memorial Cem.				Phoenix, Arizona			
23. FUNERAL DIRECTOR				24a. REC'D BY REGISTRAR			
Lee A. Patterson				24b. REGISTRAR'S SIGNATURE			
Perryville, Md.				Arthur S. Kiana			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be retained by the funeral director, and in any event, within 72 hours after death, the State Board of Health prior to burial, cremation, or removal.

VR A15 (4)  
15M 9/59

Item 20 Film 276 12-1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12620

CERTIFICATE OF DEATH

12595

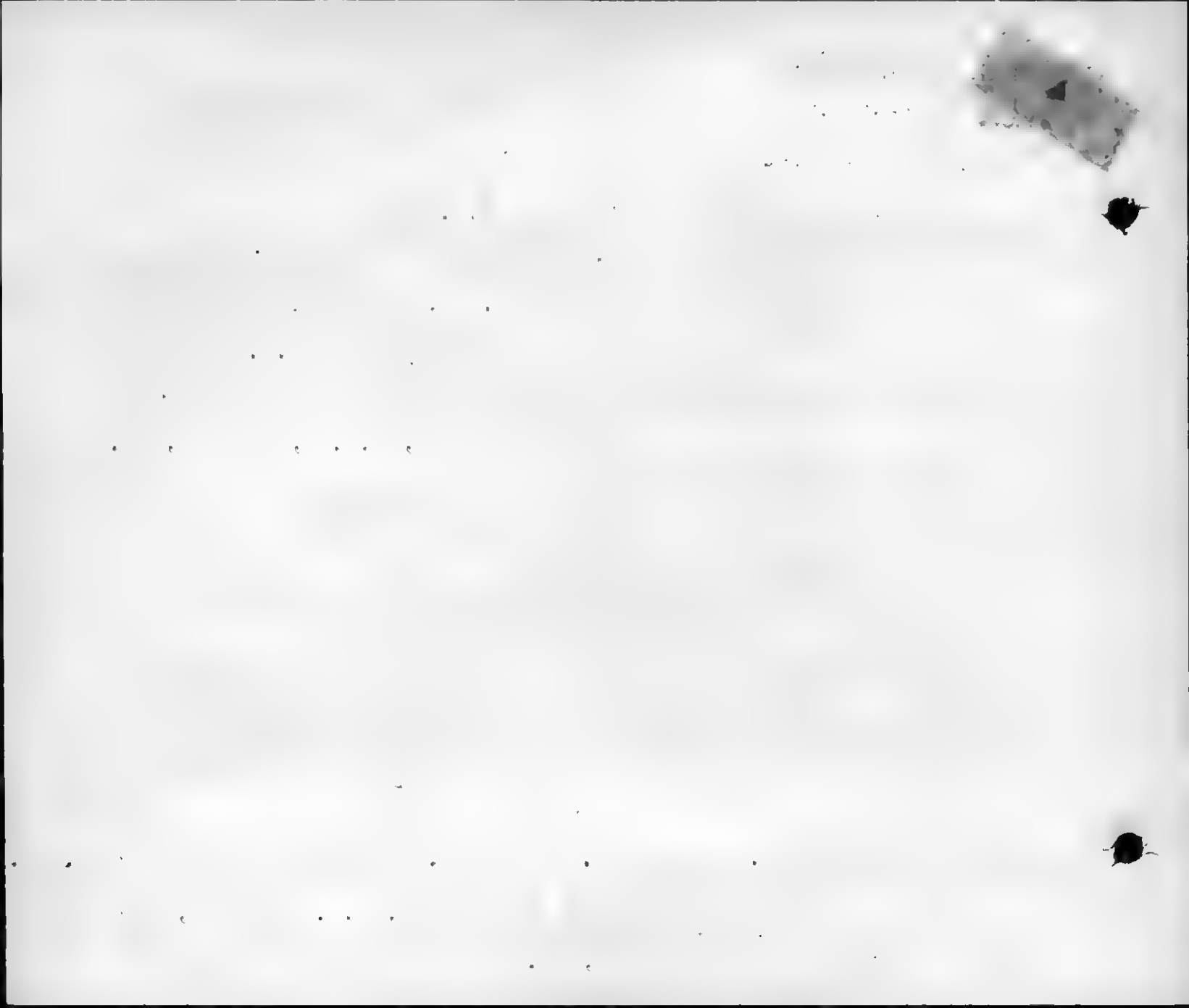
1. PLACE OF DEATH COUNTY <b>HARFORD</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAVRE DE GRACE</b>		c. LENGTH OF STAY IN 1b <b>24 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD Memorial Hosp.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL BEL AIR</b>	
3. NAME OF DECEASED (Type or print) <b>MATILDA First Middle Last</b> <b>MATILDA XXXXX E. COOPER</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>29</b> Year <b>1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 21, 1878</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Delaware N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>BRYON SPENCER</b>		14. MOTHER'S MAIDEN NAME <b>CHARITY OSBOENE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>*** ** *</b>	
17. INFORMANT <b>Bert Coomes, R.D. 2, Bel Air, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>2° + 3° Body Burn (6590.)</b> <b>916.9</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>916.9</b> DUE TO (c) <b>916.9</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Gas stove exploded, when lighting it. Suspected leak</b> INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Gas stove exploded, when lighting it. Suspected leak</b>	
20c. TIME OF INJURY Month <b>Nov</b> Day <b>29</b> Year <b>1960</b> Hour <b>4:15</b> o. m. <b>PM</b> p. m. <b>PM</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Bel Air, Harford, Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 5, 1960</b> , to <b>Nov. 29, 1960</b> , that (I) (we) last saw the deceased alive on <b>Nov. 29, 1960</b> , and that death occurred at <b>4:15 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Frank D. Hauber</b>		22b. DATE SIGNED <b>11/30/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Frank D. Hauber, M.D.</b>		22d. ADDRESS <b>610 S. Union Ave, Havre de Grace, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/2/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Baptist Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>R.D., Bel Air, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John F. Tarring</b>		25a. REC'D BY REGISTRAR <b>DEC 7 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Guthrie L. Hauber</b>		25c. ADDRESS <b>Tarring Funeral Home, Aberdeen, Md.</b>	

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12596

12621

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harro de Grace</u>		c. LENGTH OF STAY IN 1b <u>42 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>518 Washington St</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harro de Grace</u>	
f. STREET ADDRESS <u>1518 Washington St</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Percy E. Davis</u>		4. DATE OF DEATH <u>November 29 19 60</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/6/1895</u>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Peter Pan Captain Ship</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Abden Perryman</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>George H. Davis</u>		14. MOTHER'S MAIDEN NAME <u>Adeline Lilly</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mrs. Lillian H. Davis</u>		Address <u>518 D. Washington Harro de Grace, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Poisoning</u> Poisoning due to <u>CO</u> <u>891.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Started car in very small closed garage</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>11/29/60</u> 19 p. m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Garage</u>	20f. (City or town) <u>Harro de Grace</u> (County) <u>Harf</u> (State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <u>Bel Air, Md.</u> DATE SIGNED <u>11-29-60</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer-MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>12/2/60</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Longfellow</u>	22d. LOCATION (City, town, or county) (State) <u>Harro de Grace, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Perryman</u>		24a. REC'D BY REGISTRAR <u>DEC 5 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





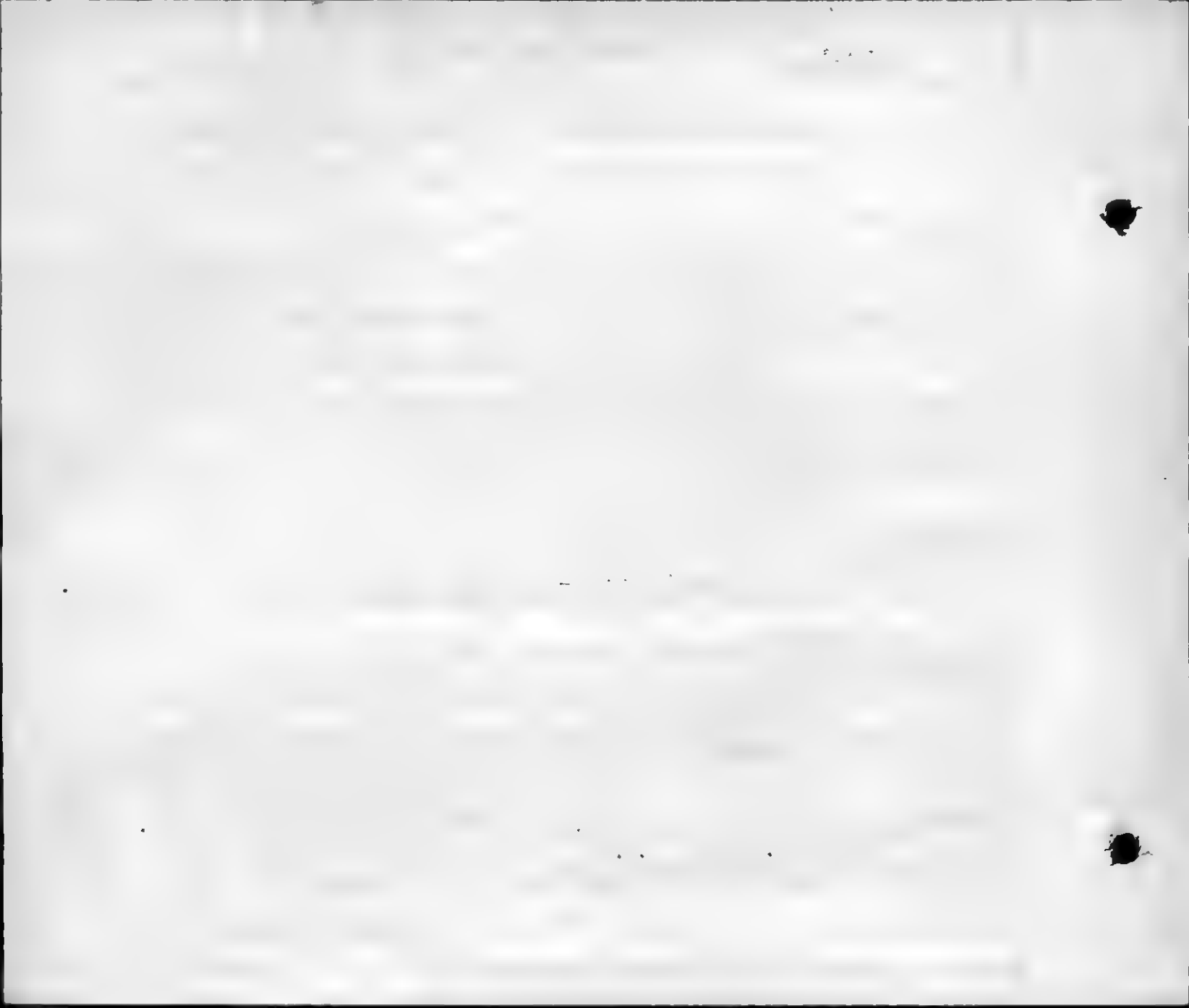
TO HOSPITAL OR ATTENDING PHYSICIAN: The low equi that the death certificate be executed within 24 hours after death. Page 4  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the registrar prior to burial, cremation, or removal, and in only event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 Items 1, 2 Film G274 11-14-60 et  
**CERTIFICATE OF DEATH**

12597

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Street</u>		c. LENGTH OF STAY IN 1b <u>X</u> Street(rural)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At home</u>		d. STREET ADDRESS <u>---</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>P.</u> Last <u>Heckman</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>4</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 5, 1873</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James P. Heckman</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Thompson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Wm. Heckman</u>		Address <u>Harlington</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Cardio-vascular Disease</u> DUE TO (c) <u>10 yrs.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov 4, 1949</u> to <u>Nov 4, 1960</u> , that I last saw the deceased alive on <u>Nov 3, 1960</u> , and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Willard P. Hudson</u> M.D. <u>Forest Hill, Maryland</u> <u>Nov. 4, 1960</u> SIGNATURE <u>WILLARD P. HUDSON, M.D.</u> NAME (Type) <u>Forest Hill, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Nov 7, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Dublin Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Harford Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>		24. REC'D BY REGISTRAR DATE <u>NOV 9 '60</u>	
ADDRESS <u>Harlington</u>		24b. REGISTRAR'S SIGNATURE <u>C. S. S. Kuma</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

12622

12598

1. PLACE OF DEATH a. COUNTY <i>Hartford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Hartford</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>HAVRE de Grace</i>				c. LENGTH OF STAY IN 1b <i>2 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Hartford Memorial Hospital</i>				e. STREET ADDRESS <i>Whiteford</i>			
3. NAME OF DECEASED (Type or print) First <i>Goldie</i> Middle <i>Irene</i> Last <i>DuBree</i>				4. DATE OF DEATH Month <i>November</i> Day <i>27</i> Year <i>1960</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Apr. 22, 1907</i>	9. AGE (In years last birthday) <i>53</i> yrs	IF UNDER 1 YEAR Months <i>5</i> Days <i>3</i> Hours <i>15</i> Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>	
10b. KIND OF BUSINESS OR INDUSTRY <i>HOUSEWIFE</i>				11. BIRTHPLACE (State or foreign country) <i>Ohio, USA</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Garrett Handley</i>				14. MOTHER'S MAIDEN NAME <i>Attie Handley</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>No</i>		17. INFORMANT <i>STANLEY DuBREE, WHITEFORD, MD.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Shock + fluid imbalance</i> 561.5 DUE TO (b) <i>Intestinal Obstruction</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <i>Exacerbated hernia (5 days)</i>							INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>5 days</i> <i>5 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Dealtos given surgery</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <i>Nov</i> Day <i>19</i> Year <i>1960</i> Hour <i>a.m.</i> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>11-27</i> to <i>11-27</i> , 19 <i>60</i> that (I) <i>yes</i> last saw the deceased alive on <i>11-27</i> , 19 <i>60</i> , and that death occurred at <i>10:15</i> A.M., from the causes and on the date stated above.							
22a. SIGNATURE <i>Wm. F. Handley</i>				22b. DATE SIGNED <i>11-27-60</i>		22c. PHYSICIAN'S NAME (Type) <i>Wm. F. Handley</i>	
22d. ADDRESS <i>Havre de Grace</i>				22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>11-30-60</i>		23c. NAME OF CEMETERY OR CREMATORY <i>DARLINGTON</i>		23d. LOCATION (City, town, or county) (State) <i>DARLINGTON, MD.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John H. Harbison, Delta, Pa.</i>				25a. REC'D BY REGISTRAR DATE <i>NOV 29 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Finner</i>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

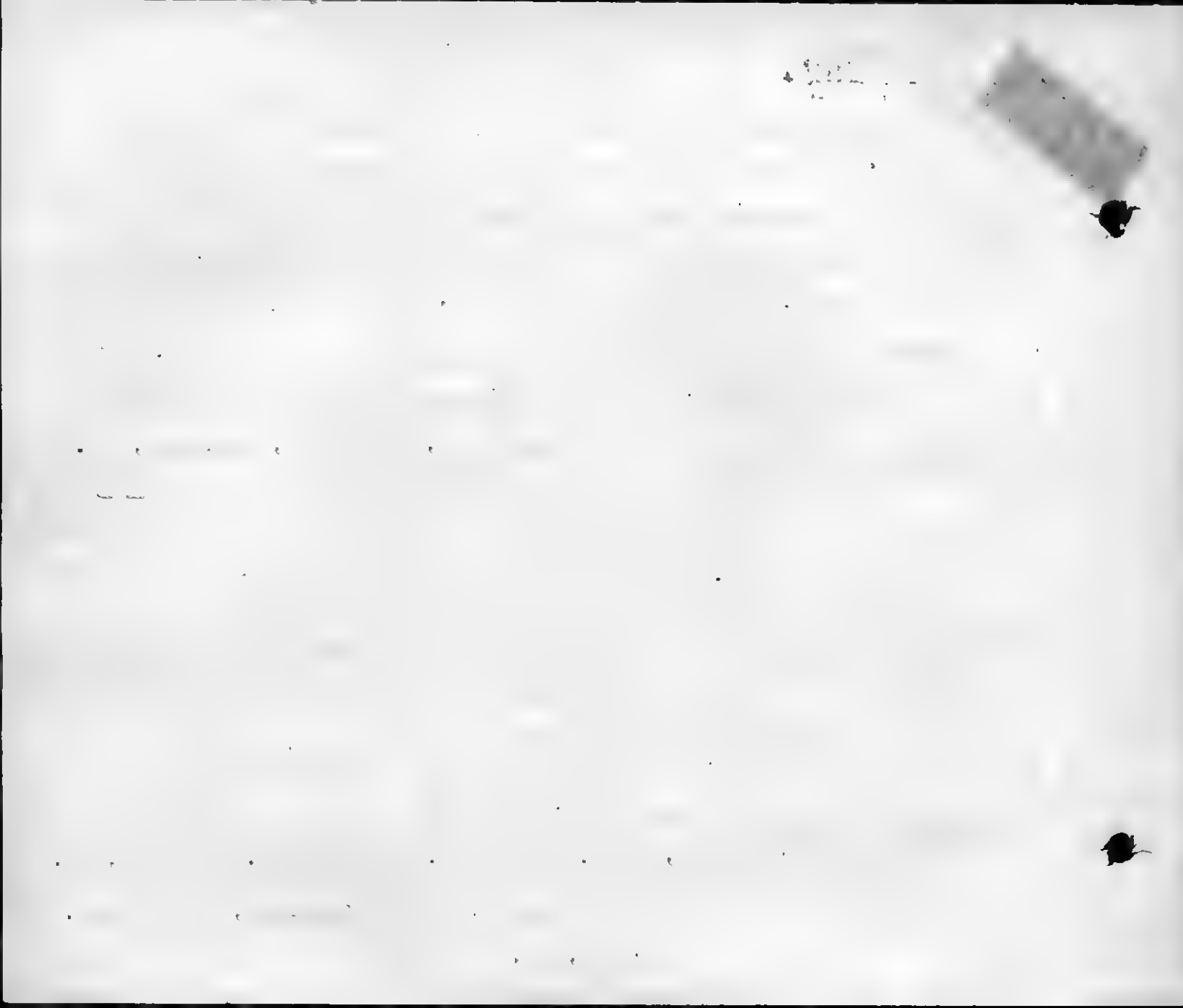
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ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12623

12599

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. LENGTH OF STAY IN lb <u>3 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		31	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hosp.</u>		d. STREET ADDRESS <u>414 Park Street</u>	
3. NAME OF DECEASED (Type or print) <u>Rebecca</u> First Middle Last		4. DATE OF DEATH <u>November 27</u> 19 <u>60</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 28, 1884</u> 76 yrs
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Morris Schneider</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Fred Fine, 414 Parke, Aberdeen, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Vascular Accident</u> DUE TO <u>Hypertension,</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Arterio Sclerotic heart disease</u> (b) <u>351X</u> (c) <u>5 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>10 years</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a m. p m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 15, 1960</u> to <u>Nov 25, 1960</u> , that (I) (we) last saw the deceased alive on <u>Nov 25, 1960</u> and that death occurred at <u>11 A</u> M; from the causes and on the date stated above.			
22a. SIGNATURE <u>Andre Weiss MD</u>		22b. DATE SIGNED <u>Nov 27, 60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Andre' Weiss, M.D.</u>		22d. ADDRESS <u>114 W. Bel Air Ave. Aberdeen, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>11/28/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Beth Elva Lawn Cemetery</u>		23d. LOCATION (City, town, or county) <u>Carriek, Panna.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarring</u>		25a. REC'D BY REGISTRAR <u>Tarring Funeral Home</u> DATE <u>DEC 1 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Henna</u>			



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12639 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12600

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Street</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bay Road</u>		d. STREET ADDRESS <u>1 Bay Road</u>	
3. NAME OF DECEASED (Type or print) <u>Frank</u> First <u>PAUL</u> Middle <u>Gaines</u> Last		4. DATE OF DEATH <u>November 30</u> 19 <u>60</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 18/1892</u> 68 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM H. GAINES</u>		14. MOTHER'S MAIDEN NAME <u>JANE GREEN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u>WORLD WAR I</u>		16. SOCIAL SECURITY NO. <u>220-30-0932</u>	
17. INFORMANT <u>MRS MATILDA M. GAINES</u> Address <u>STREET, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>25W Cerebrum</u> <u>976X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self with rifle</u>			
20c. TIME OF INJURY Month, Day, Year <u>11-30</u> 19 <u>60</u> Hour <u>11</u> a.m. <u>30</u> p.m.		20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u> (City or town) <u>Harford</u> (County) <u>MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel A. H. H.</u> DATE SIGNED <u>4-30-60</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL, SPOULING <u>BURIAL</u>		22b. DATE THEREOF <u>DEC. 3-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK CEMETERY</u>		22d. LOCATION (City, town, or county) <u>BALTIMORE MD.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BURGEE FUNERAL HOME</u> ADDRESS <u>3631 FALLS ROAD</u>		24a. REC'D BY REGISTRAR <u>Arthur L. H.</u> DATE <u>DEC 2 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. H.</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and any event within 72 hours after death.

VS. A15ME  
SM 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1  
FOR STATE  
HEALTH DEPT

12640 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12641

1. PLACE OF DEATH a. COUNTY <u>Harford</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if last habitation: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fallston</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fallston</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Pleasantville Rd</u>		d. STREET ADDRESS <u>Pleasantville Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Marie Louise Livens</u>		4. DATE OF DEATH <u>November 23 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 19-1904</u> 56 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Handby W Va</u>	
13. FATHER'S NAME <u>George Irvin Gellispie</u>		14. MOTHER'S MAIDEN NAME <u>Ida Dell Chapman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-20-7134</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive C.V. disease</u> 443 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Lorald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md.</u>	
EXAMINER'S NAME (Type) <u>Geordie Palmer MD</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>11-23-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 26-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mountain Christian</u>		22d. LOCATION (City, town, or country) <u>Joppa, Md</u>	
23. FUNERAL DIRECTOR <u>W. H. Archer, Benson, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 28 60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

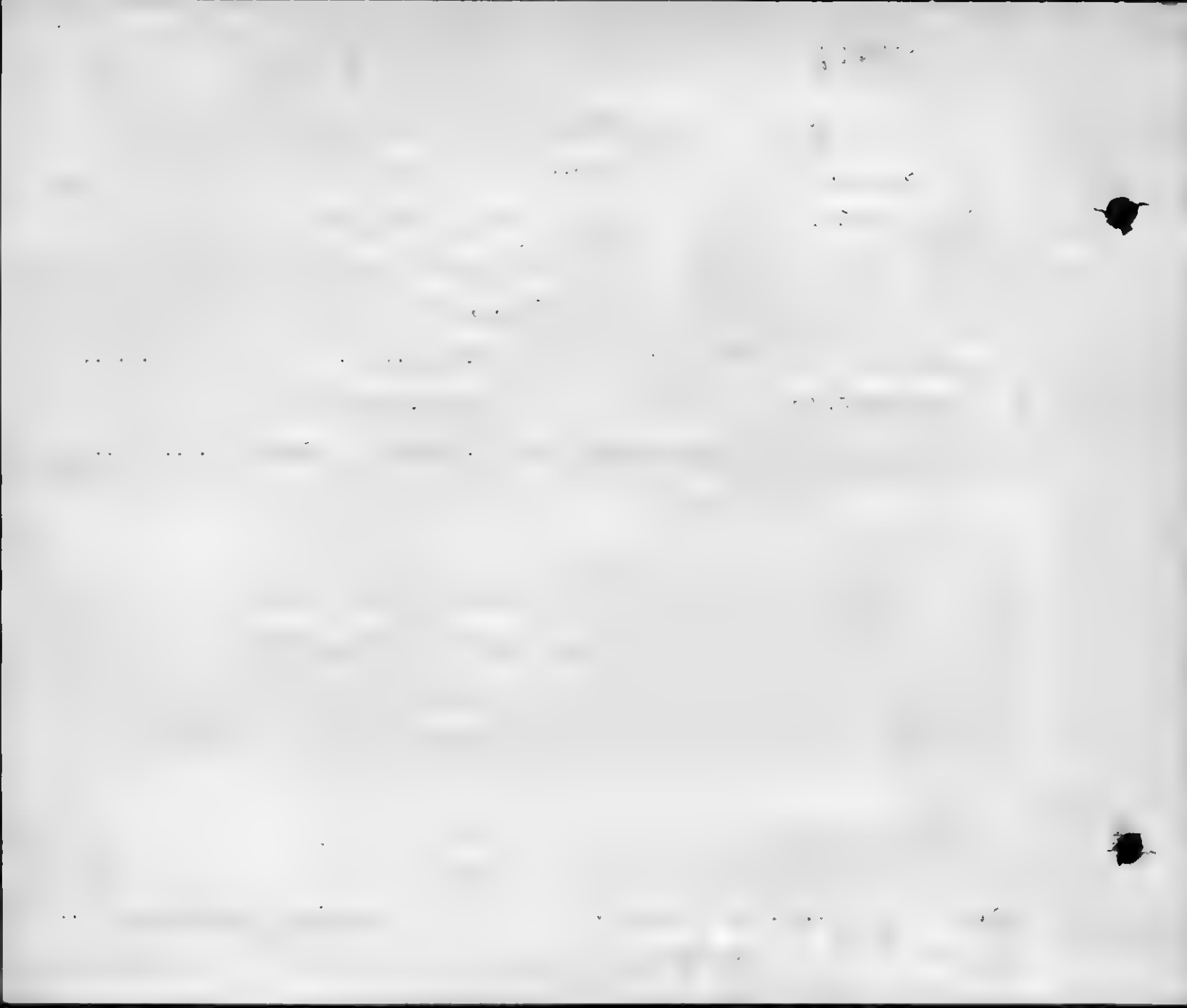
1  
FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12641 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12602

1. PLACE OF DEATH a. COUNTY <u>Harford</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u> c. LENGTH OF STAY IN b <u>10 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>RD 2 Box 61</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u> d. STREET ADDRESS <u>RD 2</u>	
3. NAME OF DECEASED (Type or print) <u>Robert Lincoln Gullion</u>		4. DATE OF DEATH <u>November 9 1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 2, 1904</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Smith Co., Va.,</u>	
13. FATHER'S NAME <u>William J. Gullion</u>		14. MOTHER'S MAIDEN NAME <u>Mary L. Turner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>223-20-0480</u>	
17. INFORMANT <u>Anna I. Gullion</u>		Address <u>Bel Air R.D., Md.,</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Due to</u> (c) <u>Due to</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, W</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>11-9-60</u>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 12, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove</u>		22d. LOCATION (City, town, or country) (State) <u>Bel Air Harford Md.,</u>	
23. FUNERAL DIRECTOR <u>Howard K. McComas</u>		ADDRESS <u>Abingdon, Md.,</u>	
24a. REC'D BY REGISTRAR <u>NOV 15 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hays</u>	





12624

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12603

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>HARFORD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAUCE DE GRACE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X RURAL BELAIR</b>	
c. LENGTH OF STAY IN 1b <b>2 DAYS</b>		d. STREET ADDRESS <b>1 Rt 2 Box 355</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD Memorial Hosp.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>DEUARD M</b> First Middle Last		4. DATE OF DEATH <b>NOVEMBER 9</b> Month Day Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 26, 1904</b>
9. AGE (In years last birthday) <b>56</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Transport Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>BRUCE HACKLER</b>		14. MOTHER'S MAIDEN NAME <b>Cynthia Hash</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>216-01-1659</b>	
17. INFORMANT <b>Mrs. Deuard M. Hackler, Bel Air, Md.</b>		Address <b>RD. 2, B.255</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Paralytic ileus</b> 5 1 1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute + subacute pancreatitis</b> DUE TO (c) <b>Alcoholism</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>2 weeks</b> <b>?</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cirrhosis of the liver</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 7th, 1960</b> to <b>Nov. 9th, 1960</b> that (I) (we) last saw the deceased alive on <b>Nov. 9th, 1960</b> and that death occurred at <b>4:10 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Edward C. Loo</b>		22b. DATE SIGNED <b>Nov. 10th, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edward C. Loo, MD</b>		22d. ADDRESS <b>211 North Union Ave, Hauce de Grace, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/11/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gardens, Bel Air, Maryland</b>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Tarring</b>		25a. REC'D BY REGISTRAR <b>DATE NOV 14 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>John G. Tarring</b>		25c. REGISTRAR'S SIGNATURE <b>John G. Tarring</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1.115

1  
FOR STATE  
HEALTH DEPT.

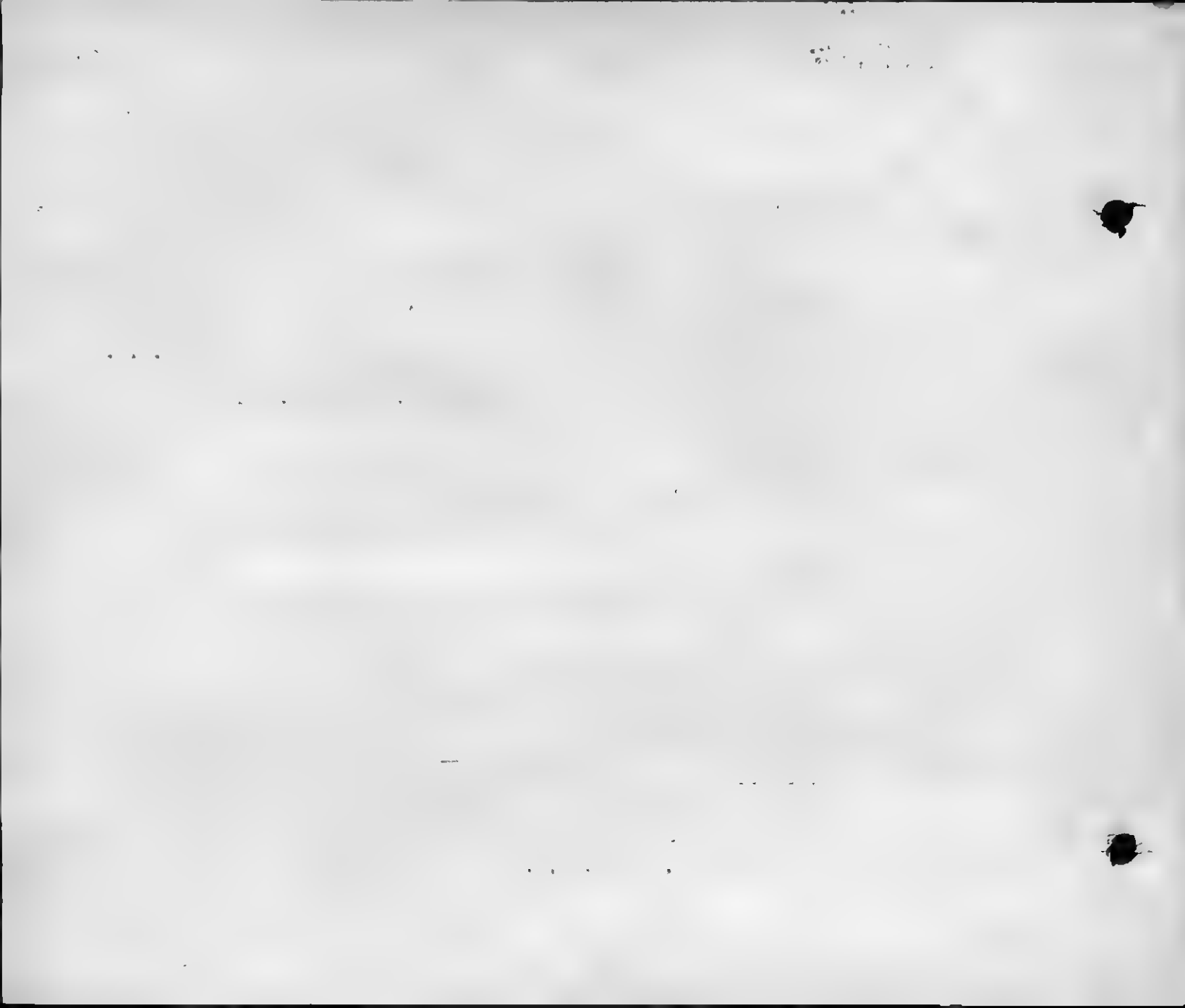
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the Director. Give pages 1, 2, and 3 to the Registrar. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
12642 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12644

1. PLACE OF DEATH a. COUNTY <b>Harford</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Edgewood</b> c. LENGTH OF STAY IN b. <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>51 Battle Street</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Edgewood</b> d. STREET ADDRESS <b>51 Battle Street</b>	
3. NAME OF DECEASED (Type or print) <b>CONSTANCE LAJOYCE HILL</b>		4. DATE OF DEATH Month <b>November</b> Day <b>1</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 20, 1960</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		9b. AGE (in years last birthday) <b>2</b> yrs. <b>11</b> Months <b>11</b> Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Eddie Hill</b>		14. MOTHER'S MAIDEN NAME <b>Alma Hall, Edgewood, Maryland</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes give year or dates of service)</b>		16. SOCIAL SECURITY NO. <b>17. INFORMANT Address</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Interstitial pneumonitis</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
ACTUAL SIGNATURE <b>Charles S. Petty</b> M.D. EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b> 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>11/3/60</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b> 22d. LOCATION (City, town, or country) (State) <b>Harford County Maryland</b>		DATE SIGNED <b>11/2/60</b>
23. FUNERAL DIRECTOR <b>Elmer E. Bullock</b> ADDRESS <b>Harford County</b> 24a. REC'D BY REGISTRAR <b>NOV 7 '60</b> 24b. REGISTRAR'S SIGNATURE <b>Charles S. Petty</b>		



may be required by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12625

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

### CERTIFICATE OF DEATH

12605

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>House de Grace</u>		c. LENGTH OF STAY IN 1b <u>1/2 hr</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>House de Grace, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				d. STREET ADDRESS <u>1136 Wiler St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Alpha</u> First <u>Keien</u> Last				4. DATE OF DEATH Month <u>November</u> Day <u>10</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/20/1893</u>		9. AGE (In years last birthday) <u>67</u> yrs	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Marlinton W.Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jasper Enoch</u>				14. MOTHER'S MAIDEN NAME <u>Martha Clayton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>not</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Ray Rein</u> Address <u>134 Green St Harford Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Conduction Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Arterio Sclerotic Heart Disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> 19. WAS A JUPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/8/60</u> to <u>11/10/60</u> , that (I) (we) last saw the deceased alive on <u>Nov 10, 1960</u> , and that death occurred at <u>10:15</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>John L. Wadsworth</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>11/11/60</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>11/13/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Principio</u>		23d. LOCATION (City, town, or county) (State) <u>Principio Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Pennington</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 14 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Charles E. Harris</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

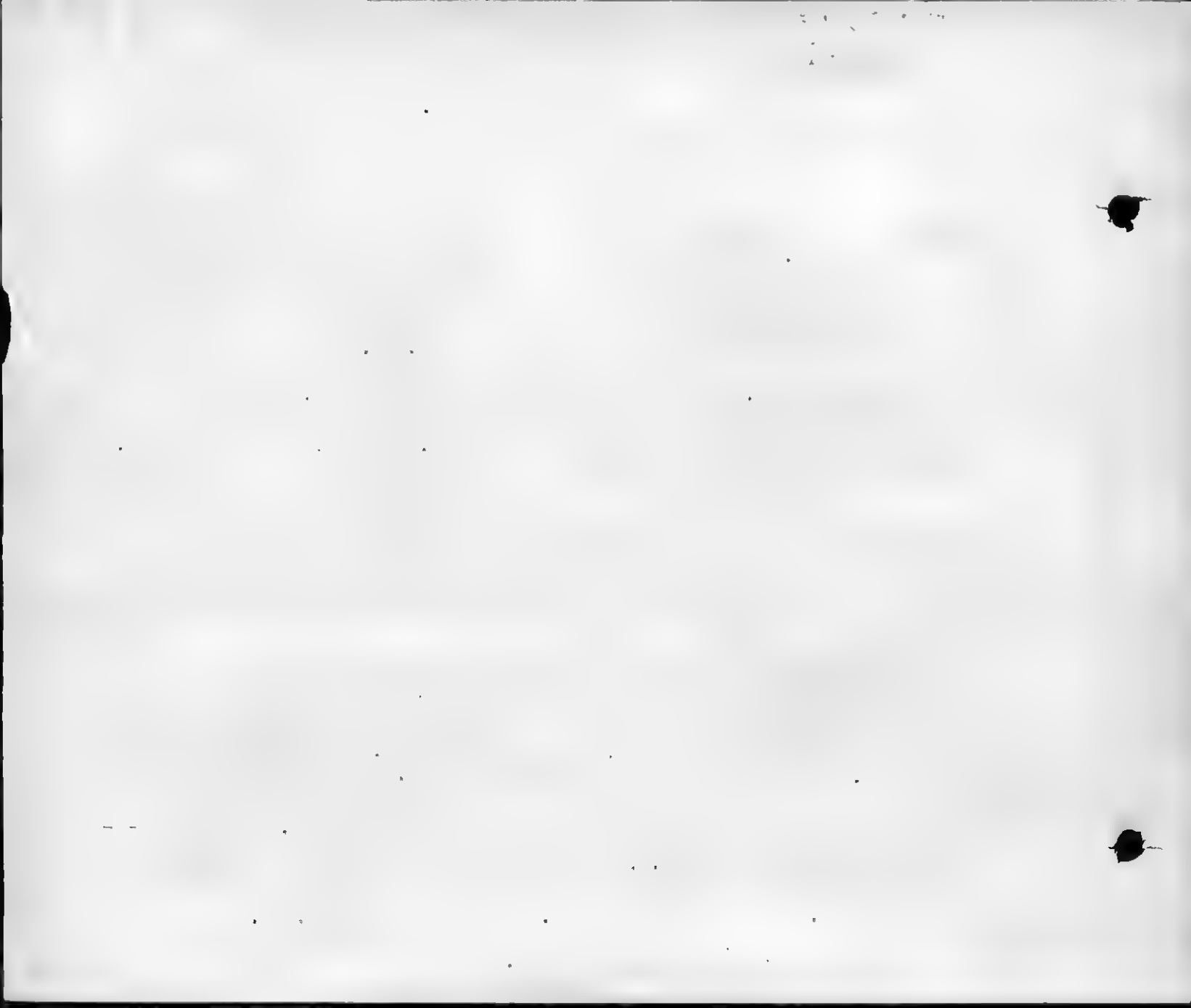
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 12606

12643

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md. b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rocks		c. LENGTH OF STAY IN 1b 2 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rocks	
f. STREET ADDRESS 1		g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles G. Koether		4. DATE OF DEATH Month November 6 Day 6 Year 19 60	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 14 1888
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Geo. E.A. Koether		14. MOTHER'S MAIDEN NAME Catherine M. Kusterer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -- --		16. SOCIAL SECURITY NO -- --	
17. INFORMANT Frederick Wm. Koether		Address 2816 Alvarado Sq. 14	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic CV Disease 442.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 1, 1959, to Nov. 6, 1960, that I last saw the deceased alive on Oct. 30, 1960, and that death occurred at 11 A. M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Gerald C. Palmer M.D.		Bo-Air, Md. 11-6-60	
PHYSICIAN'S NAME (Type) Gerald C. Palmer M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 9, 1960	22c. NAME OF CEMETERY OR CREMATORY Lorraine Cem.	22d. LOCATION (City, town, or county) (State) Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Philo Henry Sons		ADDRESS 2024 Orleans St. 31	
24a. REC'D BY REGISTRAR NOV 9 1960		24b. REGISTRAR'S SIGNATURE	





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12620 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12607

1. PLACE OF DEATH a. COUNTY <u>Harford</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harford</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harford Memorial Hospital</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u> d. STREET ADDRESS <u>1569 Cressy Road</u>		
3. NAME OF DECEASED (Type or print) <u>A. Anastasio E. Kourniotis</u> First Middle Last 4. DATE OF DEATH <u>November 23 1960</u> Month Day Year			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>1886</u> Yrs. Months Days			9. AGE (in years last birthday) <u>74</u> IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Mins.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>RESTAURANT</u> 11. BIRTHPLACE (State or foreign country) <u>Greece</u> 12. CITIZEN OF WHAT COUNTRY? <u>Greece</u>			13. FATHER'S NAME <u>Elias Kourniotis</u> 14. MOTHER'S MAIDEN NAME <u>Helen</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>214409580</u> 16. SOCIAL SECURITY NO. <u>214409580</u> 17. INFORMANT <u>JOHN KANAIS</u> Address <u>3822 Glen Arm Ave (6) BALTO.</u>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Compound, comminuted fractures both bones both legs</u> DUE TO (b) <u>bones both legs</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>A nts accident</u> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>11-23-60</u> Hour <u>7</u> a.m. <u>p.m.</u> 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <u>at work</u> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Bay + transfer Sta</u> 20f. (City or town) (County) (State) <u>Bel Air Harford Md.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D. EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md.</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>11-24-60</u> Address (Street, city, town, or county)			22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 22b. DATE THEREOF <u>11/26/60</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Greek Ortho. Cem.</u> 22d. LOCATION (City, town, or country) (State) <u>BALTIMORE Md.</u>		
23. FUNERAL DIRECTOR <u>L. J. RUCK</u> ADDRESS <u>5305 HARFORD ROAD</u> 24a. REC'D BY REGISTRAR <u>NOV 28 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>					

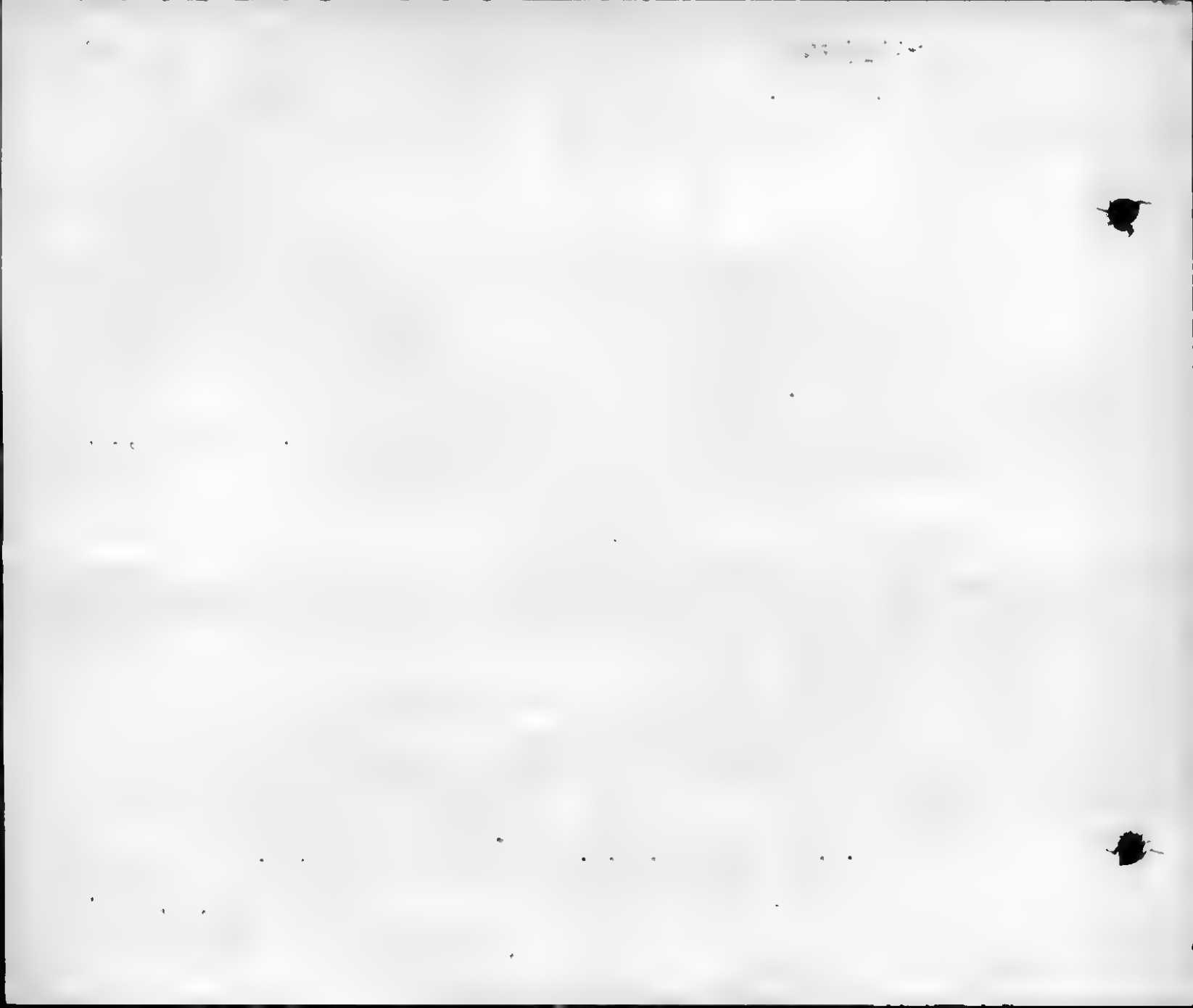


12627

**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

12608

1 PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Harre-de-Grace</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit</b>	
c. LENGTH OF STAY IN 1b <b>8 hrs.</b>		d. STREET ADDRESS <b>R.D. I</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Harford Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary</b> First <b>B. Linton</b> Middle <b>Lost</b>		4. DATE OF DEATH <b>11 18 1960</b> Month <b>11</b> Day <b>18</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-10-1880</b>
9. AGE (In years lost birthday) <b>80 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-wife</b>	
11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>George W. Brown</b>		14. MOTHER'S MAIDEN NAME <b>Annie Isaac</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>317-07-0890</b>	
17. INFORMANT <b>Mrs Philip Morrison, Perryville, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>Diabetes</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) <b>10 days</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 4</b> 1960, to <b>Nov 18</b> 1960, that (I) (we) lost saw the deceased alive on <b>Nov 18</b> 1960, and that death occurred at <b>1:40 PM</b> , from the causes and on the date stated above			
22a. SIGNATURE <b>G.H. Richards Jr.</b>		22b. DATE SIGNED <b>11/19/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>G.H. Richards Jr. M.D.</b>		22d. ADDRESS <b>Port Deposit, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-21-1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Asbury</b>		23d. LOCATION (City, town, or county) (State) <b>Port Deposit, Md. Rural</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lee A. Patterson, Son</b>		25a. REC'D BY REGISTRAR <b>Perryville, Md</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>		25c. DATE <b>NOV 22 '60</b>	



TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

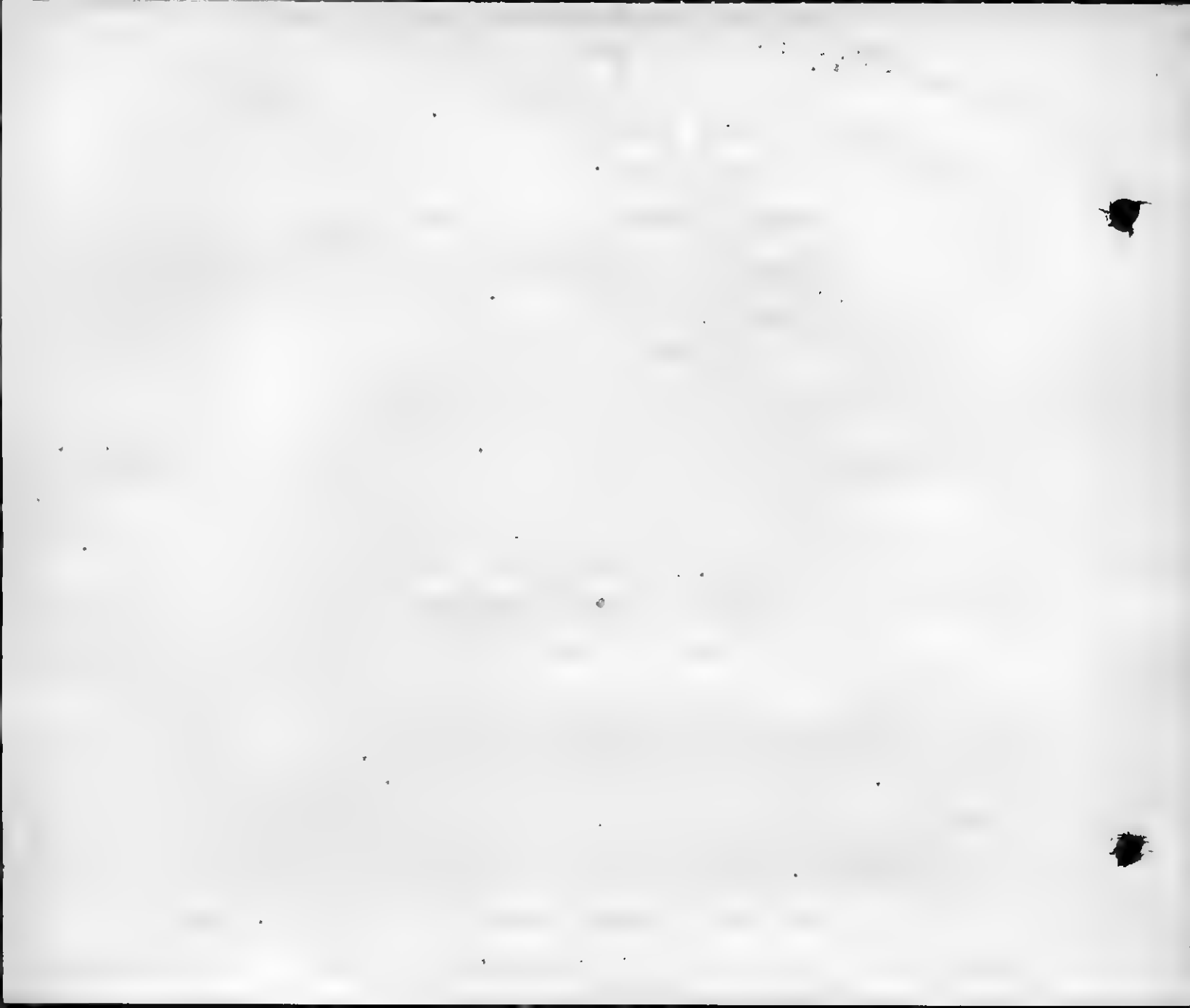
12644

## CERTIFICATE OF DEATH

Reg. Dist. No.

12609

1. PLACE OF DEATH o COUNTY Harford MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) o STATE Md. b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jarrettsville		c. LENGTH OF STAY IN 1b 5 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last EDWARD HERMAN MARCELLE		4. DATE OF DEATH Month Day Year November 9 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 30, 1881
9. AGE (In years less birthday) yrs 70		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mill Wright		10b. KIND OF BUSINESS OR INDUSTRY Slate	
11. BIRTHPLACE (State or foreign country) Vermont		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nelson Marcelle		14. MOTHER'S MAIDEN NAME Alvira Capman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 008-07-8837	
17. INFORMANT Mrs Edw. Marcelle (wife)		Address Jarrettsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Acute pulmonary edema (acute congestive heart failure) 15 min. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Decompensated chronic cardio-vascular disease & 4 yrs. DUE TO (c) Chr. pulmonary fibrosis and emphysema 15 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1950, to Nov. 9, 1961, that I last saw the deceased alive on Nov. 3, 1960, and that death occurred at 8:35 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Willard P. Hudson M.D. Forest Hill, Maryland 11-9-60			
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Willard P. Hudson			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-12-1960	
22c. NAME OF CEMETERY OR CREMATORY Belair Gardens		22d. LOCATION (City, town, or county) (State) Belair, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Delta, Penna.		24a. REC'D BY REGISTRAR DATE NOV 14 '60	
24b. REGISTRAR'S SIGNATURE Willard P. Hudson			



## CERTIFICATE OF DEATH

Reg. Dist. No.

12640

12645

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leuch</u>				c. LENGTH OF STAY IN 1b <u>5 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JUNIOUS</u> Middle <u>MARK</u> Last <u>MUSTARD</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>3</u> Year <u>1960</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 16 1892</u>		9. AGE (in years last birthday) <u>68</u> yrs.	10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>haboeee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shoe Co</u>		11. BIRTHPLACE (State or foreign country) <u>White Gate Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James H. Mustard</u>				14. MOTHER'S MAIDEN NAME <u>Hattie E. Price</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-12-6632A</u>		17. INFORMANT <u>Mrs Junious Mustard</u> Address <u>Harford Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO <u>Coronary Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>—</u> 19 <u>—</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u>				20g. (County) <u>—</u>		20h. (State) <u>—</u>	
21. I certify that I attended the deceased from <u>MAR 3</u> , 19 <u>58</u> , to <u>NOV 3</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>OCT 21</u> , 19 <u>60</u> , and that death occurred at <u>4 A.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dudley Phillips</u>				ADDRESS (Street, city or town, state) <u>DARLINGTON</u>			
PHYSICIAN'S NAME (Type) <u>Dudley Phillips MD</u>				DATE SIGNED <u>MARYLAND</u>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Nov 3, 1960</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Run Cmt</u>		22d. LOCATION (City, town, or county) (State) <u>Harford Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H &amp; Bailey</u>				ADDRESS <u>Darlington Md</u>		24a. REC'D BY REGISTRAR <u>—</u>	
				24b. REGISTRAR'S SIGNATURE <u>—</u>		DATE <u>NOV 9 '60</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

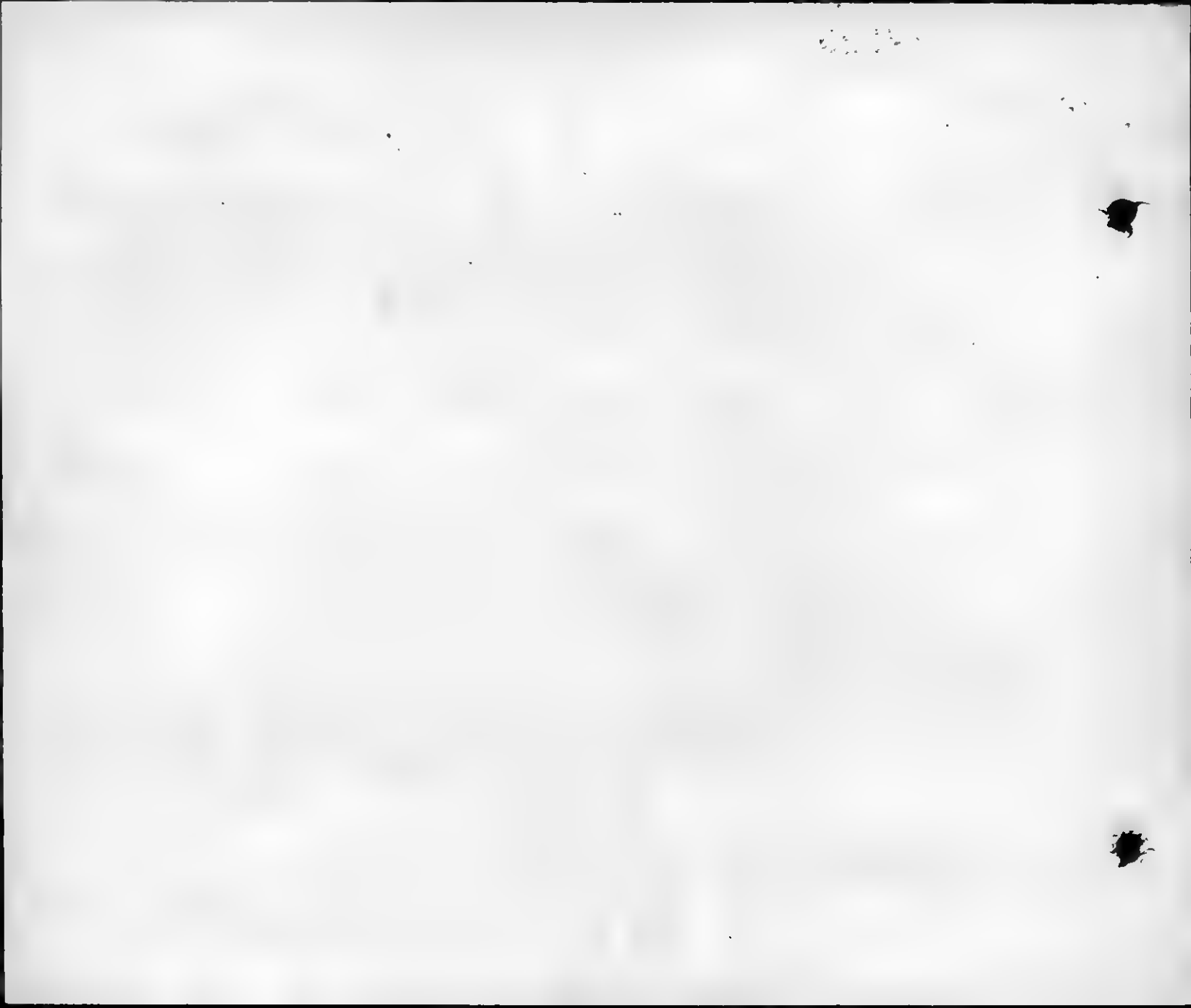
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

12628

12611

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>HARFORD</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAURE DE GRACE</b>				c. LENGTH OF STAY IN 1b <b>1 Day 20 Hrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD Memorial Hosp.</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>			
f. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD Memorial Hosp.</b>				d. STREET ADDRESS <b>402 F. North Court Rd.</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOSEPH PATRICK NORD JR.</b>				4. DATE OF DEATH Month Day Year <b>NOVEMBER 1 1960</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-31-60</b>		9. AGE (In years last birthday) yrs <b>1</b>	IF UNDER 1 YEAR Months <b>1</b> Days <b>20</b>	IF UNDER 24 HRS. Hours <b>20</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NEWBORN</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Joseph Patrick Nord</b>				14. MOTHER'S MAIDEN NAME <b>Anna Popovich</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hyaline Membrane Disease</b> <b>773.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Prematurity</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <b>10/31/60</b> to <b>11/1/60</b> , that (I) (we) last saw the deceased alive on <b>11/1/60</b> and that death occurred at <b>11:50</b> P.M. from the causes and on the date stated above							
22a. SIGNATURE <b>McCarri MD</b>		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>11/2/60</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>11/3/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Post Cemetery</b>		23d. LOCATION (City, town, or county) <b>Aberdeen Proving Gr. Md.</b>		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Farney - Aberdeen, Maryland</b>				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
				DATE <b>NOV 7 '60</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

## CERTIFICATE OF DEATH

Reg. Dist. No.

12612

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bel Air, (Rural)</b>		c. LENGTH OF STAY IN 1b <b>Bel Air (Rural)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D. #2,</b>		e. STREET ADDRESS <b>R.D. #2,</b>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>WALTER</b> Last <b>PIEPER</b>		4. DATE OF DEATH Month <b>November</b> Day <b>25</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 3, 1888</b>
9. AGE (In years last birthday) <b>72 yrs.</b>		10. IF UNDER 1 YEAR Months <b>25</b> Days <b>19</b> Hours <b>60</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Horticulturist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Nursery</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Henry Pieper</b>		14. MOTHER'S MAIDEN NAME <b>Alberta Thompson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-03-9832</b>	
17. INFORMANT <b>Mrs. W.W. Pieper, Bel Air, Md.</b>		Address <b>R.D. #2,</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of lung, left</b> <b>11-25-60</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>5 M.D.S.</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-28-60</b> , 19 <b>60</b> , to <b>11-25-60</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>11-25-60</b> , 19 <b>60</b> , and that death occurred at <b>5:50 PM</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>B. J. Plunkett Jr.</b>		ADDRESS (Street, city or town, state) <b>617 W. Bel Air Ave.</b>	
PHYSICIAN'S NAME (Type) <b>B. J. Plunkett Jr.</b>		DATE SIGNED <b>11-26-60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/28/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Spesutia Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Perryman, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Tarring</b>		24a. REC'D BY REGISTRAR <b>NOV 30 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

12647

12613

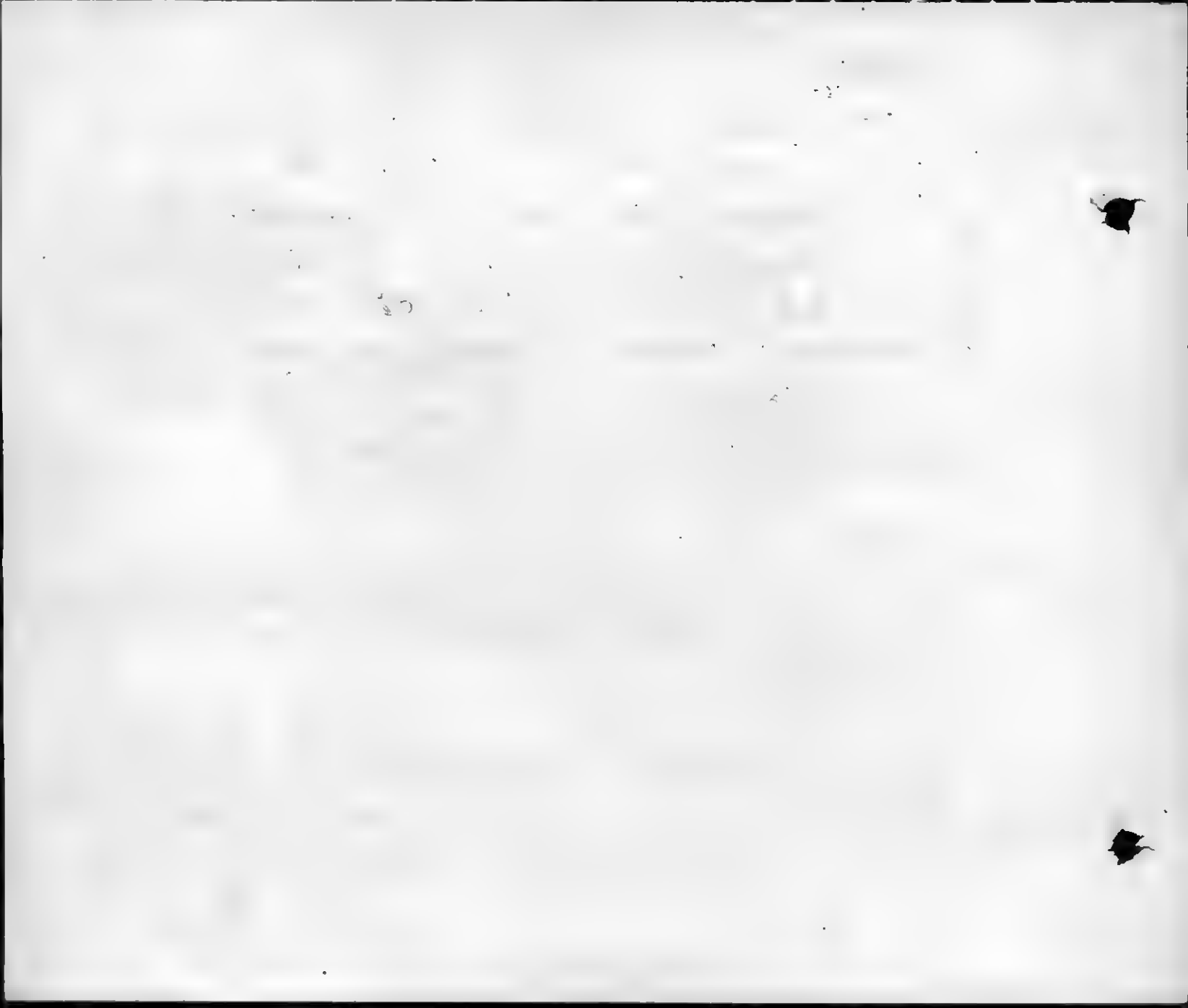
1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before address on) a. STATE <u>md</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charlton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charlton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>Wm. M. Prushy</u>				4. DATE OF DEATH <u>Nov. 22 1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 5 1880</u>	9. AGE (In years last birthday) <u>79</u> yrs	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a. JSUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer on farm</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Harford Co., Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Robert Prushy</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>213-12-334</u>		17. INFORMANT <u>Marcus Prushy</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerosis</u> <u>-31-</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Hemorrhage</u> DUE TO (c) <u>above</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Heart Condition</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/15 1960</u> to <u>11/22 1960</u> that (I) (we) last saw the deceased alive on <u>11/15 1960</u> and that death occurred at <u>9 P.</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>F. P. Brodzinski</u>				M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>11/25/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>F. P. Brodzinski</u>				22d. ADDRESS <u>Washington 7112</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Noted</u>		<u>11/26/1960</u>		<u>Haranna Cem</u>		<u>Harford Co., Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>				ADDRESS <u>Charlton, Md</u>		25a. REC'D BY REGISTRAR <u>NOV 29 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			



126i4

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. It may be signed by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral home should take it to the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the State Board of Health.





# 1 FOR STATE HEALTH DEPT. M X 1 TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. VS. A15ME 5/17/59 Nov 11

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 12614 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12615

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Harford</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u> c. LENGTH OF STAY IN b. <u>1</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Tuffin</u> d. STREET ADDRESS <u>Shirley A ne</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Office Dr Jewel C Palmer</u>				e. DATE OF DEATH <u>November 1</u> 19 <u>60</u>				f. AGE (in years last birthday) <u>4</u>	
3. NAME OF DECEASED (Type or print) <u>Linda Marie Rineholt</u>		4. DATE OF BIRTH <u>July 8, 1960</u>		5. AGE (in years last birthday) <u>4</u>		6. IF UNDER 1 YEAR <u>4</u>		7. IF UNDER 24 HRS. <u>4</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. DATE OF BIRTH <u>July 8, 1960</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>				11. PLACE OF DEATH (State or foreign country) <u>Harford Memorial Hospital</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>Ralph Rineholt</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Lucas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>✓</u>				16. SOCIAL SECURITY NO <u>✓</u>				17. INFORMANT <u>Ralph Rineholt</u> Address <u>Joppa Clayton Rd md</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO (b) <u>776X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>776X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Jewel C Palmer</u> M D				CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, md</u>				DATE SIGNED <u>11-1-60</u>	
NAME (Type) <u>Gerard C Palmer M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>4th Nov. 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Glen Burnie, md</u>	
23. FUNERAL DIRECTOR <u>R. V. Singleton</u> ADDRESS <u>Glen Burnie, Md</u>				24a. REC'D BY REGISTRAR <u>Nov 3 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kears</u>			



## 12616

VR A15 (4)  
15M 9/59



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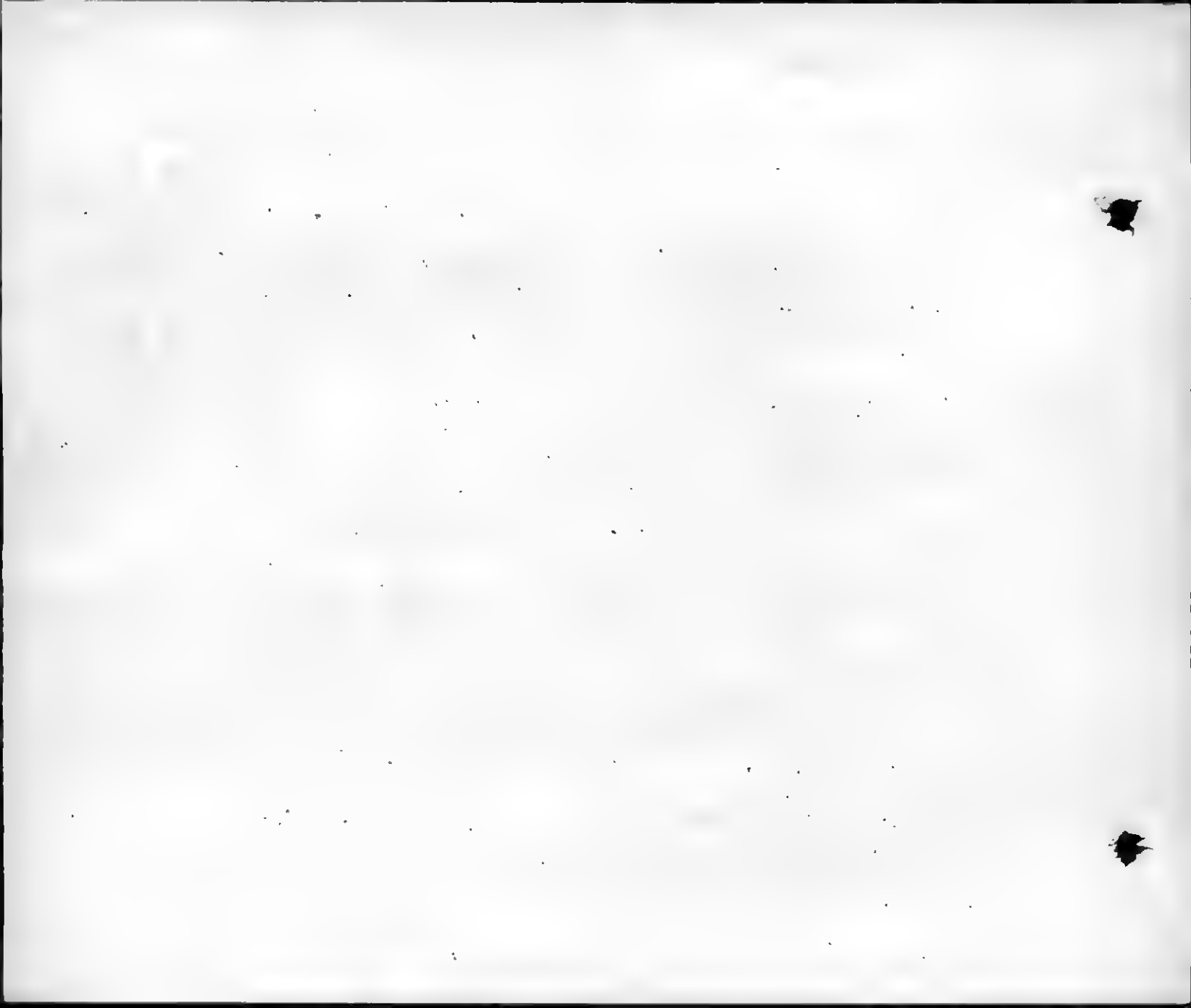
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Res'dence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pylesville</u>		c. LENGTH OF STAY IN 1b <u>6-1/2</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pylesville Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>HARKINS ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WICK LEVIE SPURLIN</u>				4. DATE OF DEATH Month Day Year <u>NOV 19 1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 20 1882</u>		9. AGE (In years last birthday) <u>78</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Sparta N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Eli Spurlin</u>				14. MOTHER'S MAIDEN NAME <u>Emmaline Hudson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>218-32-5128</u>		INFORMANT Address <u>Mrs. Zedie Spurlin Pylesville Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>Carcinoma of stomach - metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January 19 60</u> to <u>19 November 19 60</u> that I last saw the deceased alive on <u>19 November 19 60</u> and that death occurred at <u>11:50 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Reginald B. Hermsell</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Stewartstown, Pa. 11/20/60</u>			
PHYSICIAN'S NAME (Type) <u>REGINALD B. HERMSSELL</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/24/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hooker</u>		22d. LOCATION (City, town, or county) (State) <u>Sparta N.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles C. Rutz</u>				ADDRESS <u>Jarrettsville Md</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 22 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles S. Krawa</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled out by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

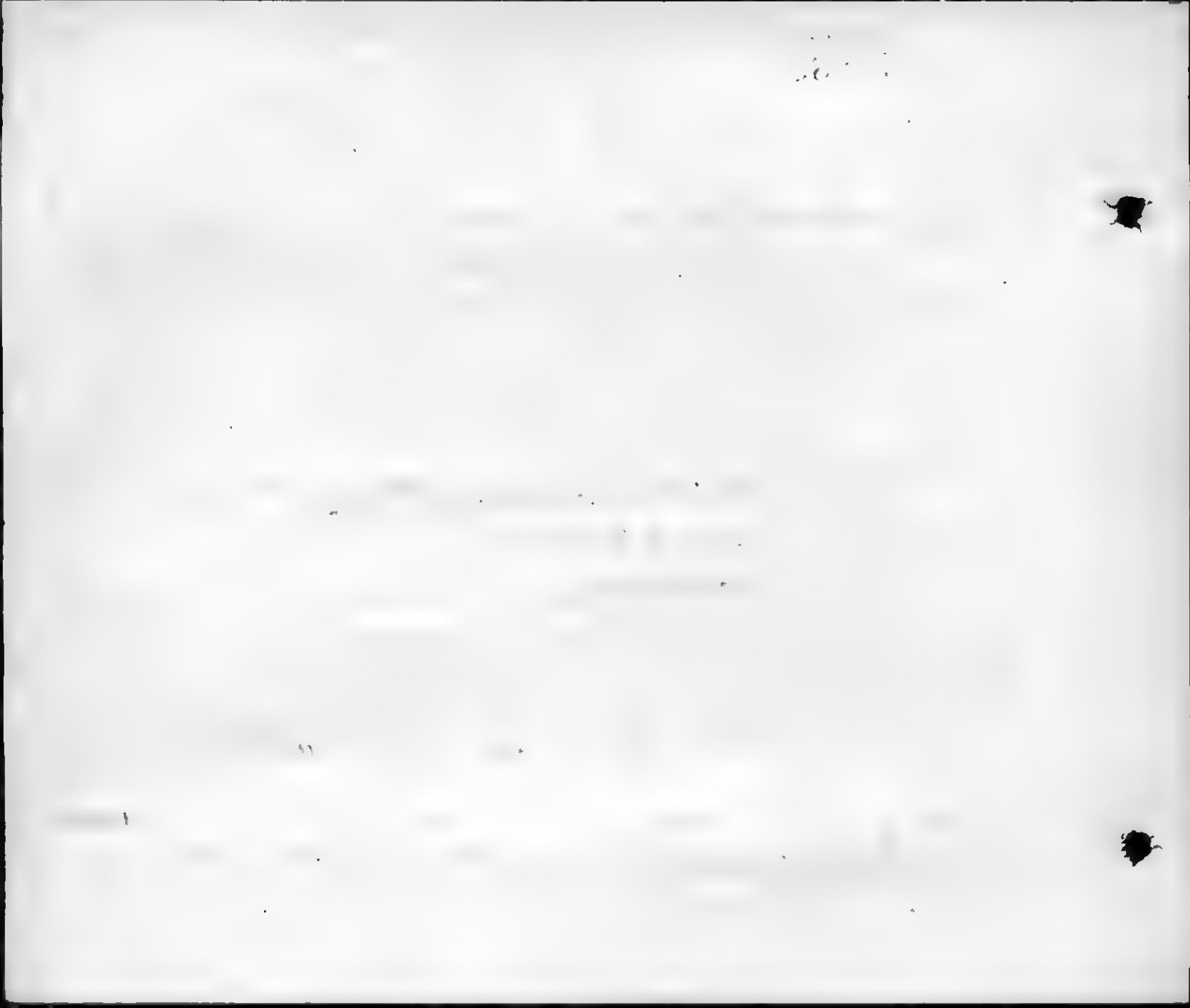
VR A15 (4)  
15M 9/59

12631

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12618

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Port Deposit</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				d. STREET ADDRESS <u>224 N. Main St.</u>			
3. NAME OF DECEASED (Type or print) First <u>PATRICIA</u> Middle <u>ANN</u> Last <u>STAMPS</u>				4. DATE OF DEATH Month <u>November</u> Day <u>8</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 13, 1939</u>		9. AGE (In years last birthday) <u>21</u> yrs	IF UNDER 1 YEAR Months <u>9</u> Days <u>25</u> Hours <u></u> Min <u></u>	IF UNDER 24 HRS. Hours <u></u> Min <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Le Roy Taylor</u>				14. MOTHER'S MAIDEN NAME <u>HANNAH SMITH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>213-36-9959</u>		17. INFORMANT <u>Mrs Hannah J. Taylor, Port Deposit, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Post Partum Hemorrhage &amp; Macrocytic Anemia</u> DUE TO (b) <u>Vaginal Laceration</u> DUE TO (c) <u>Uterine Atony</u>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day Year Hour a m p. m		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/6</u> 19 <u>60</u> to <u>11/8</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Nov 8</u> 19 <u>60</u> , and that death occurred at <u>6:55</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>George T. Stansbury</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>11/10/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>				22d. ADDRESS <u>509 Revolution St. Harford de Gray, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11/12/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Berkley Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Darlington, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles J. Bullock, Harford de Gray, Md.</u>				ADDRESS <u></u>		25a. REC'D BY REGISTRAR <u></u> 25b. REGISTRAR'S SIGNATURE <u></u>	
				DATE <u>NOV 14 '60</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)  
ISM 9/59

12632

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12619

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>HARFORD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAURE DE GRACE</b>		c. LENGTH OF STAY IN 1b <b>3 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD Memorial Hosp.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ABERDEEN</b>	
3. NAME OF DECEASED (Type or print) First <b>Edward I</b> Middle <b>Tobin</b> Last <b>Tobin</b>		4. DATE OF DEATH Month <b>November</b> Day <b>10</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 16, 1890</b>
9. AGE (In years last birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR Months <b>70</b> Days <b>70</b> Hours <b>70</b> Min <b>70</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer (Retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JERRY Tobin</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE Brown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>None</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>222 S. Parke</b>	
17. INFORMANT <b>Jerry W. Tobin, Aberdeen, Maryland</b>		18. ADDRESS <b>222 S. Parke</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>331X</b> DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral arteriosclerosis</b> DUE TO (c) <b>~ sign</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>11</b> p. m. <b>10</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>Nov 9, 1960</b> to <b>Nov 10, 1960</b> , that (I) (we) last saw the deceased alive on <b>Nov 10, 1960</b> , and that death occurred at <b>2:55 PM</b> , from the causes and on the date stated above			
22a. SIGNATURE <b>B. J. Plunkett Jr.</b>		22b. DATE SIGNED <b>11-11-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>B. J. Plunkett Jr., M.D.</b>		22d. ADDRESS <b>617 W. Bel Air Ave, Aberdeen, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/14/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Bakers Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Aberdeen, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Barry</b>		25a. REC'D BY REGISTRAR <b>Tarring Funeral Home</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>		DATE <b>NOV 16 '60</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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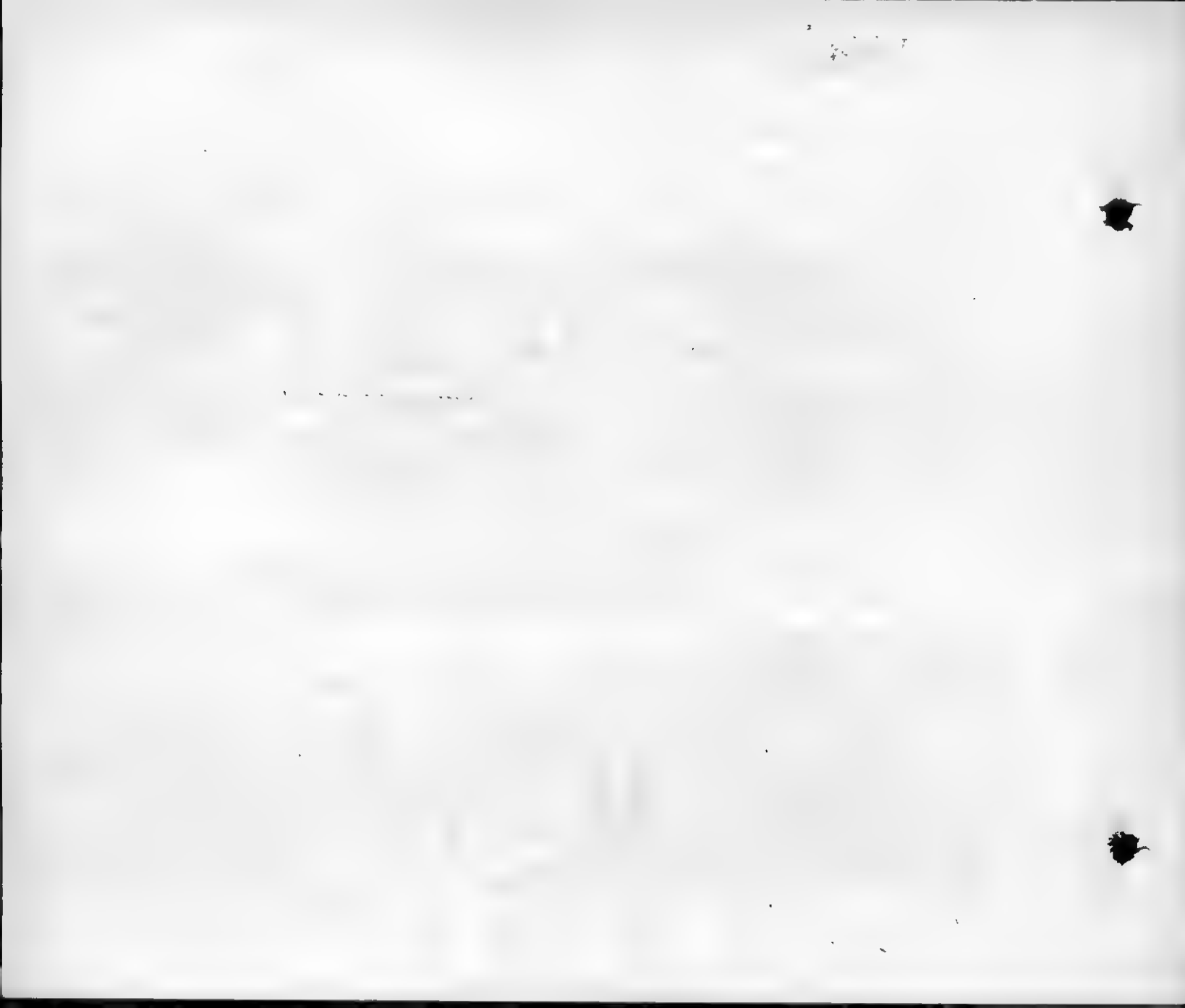
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12633

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12640

1 PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>George Emanuel TriFillis</u>		4. DATE OF DEATH <u>11/16/60</u>	
5. SEX <u>Male</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>3-24-11</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner, Harford</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Screen Br's Trailer Ct</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Emanuel TriFillis</u>		14. MOTHER'S MAIDEN NAME <u>Anna Kourouniotis</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16 SOCIAL SECURITY NO <u>VA 40-140000000</u>	
17 INFORMANT <u>Valerie TriFillis</u>		Address <u>4 Bros. Trailer Court</u>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4</u> <u>Coronary Occlusion</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH _____	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____		20d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 5</u> , 19 <u>60</u> , to <u>11-16-60</u> , that (I) (we) last saw the deceased alive on <u>11-16-60</u> , and that death occurred at _____ M, from the causes and on the date stated above.			
22a SIGNATURE <u>[Signature]</u> M.D.		22b DATE SIGNED _____	
22c PHYSICIAN'S NAME (Type) _____		22d ADDRESS _____	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>11/19/60</u>		23b DATE THEREOF <u>11/19/60</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		23d LOCATION (City, town, or county) (State) <u>Harford, Md.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		25a REC'D BY REGISTRAR <u>DATE 21 '60</u>	
25b REGISTRAR'S SIGNATURE <u>[Signature]</u>			



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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12615

## CERTIFICATE OF DEATH

12621

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		STATE <u>MARYLAND</u>		COUNTY <u>HARFORD</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR</u>		LENGTH OF STAY (In this place) <u>Lifetime</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>230 N. BOND ST.</u>		STREET ADDRESS (If rural give location) <u>230 N. BOND ST.</u>					
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>SARAH</u> (Middle) <u>ELIZABETH</u> (Last) <u>WHITTINGTON</u>				(Month) <u>NOV</u> (Day) <u>25</u> (Year) <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>COL.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>DIVORCED</u>	8. DATE OF BIRTH <u>OCTOBER 12, 1878</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LEVY WILSON</u>				14. MOTHER'S MAIDEN NAME <u>HANNAH BARRETT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT & ADDRESS <u>GENEVIEVE PEAKER 230 N. BOND ST. BEL AIR, MD.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
4221 IMMEDIATE CAUSE (A) <u>CONGESTIVE HEART FAILURE</u>						<u>1 week</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>						<u>20 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) _____							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic glomerular Nephritis; Bronchopneumonia</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>APRIL 19, 1955</u> , to <u>Nov 25, 1960</u> , that I last saw the deceased alive on <u>Nov 24, 1960</u> , and that death occurred at <u>4:00 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Paul S. Stonecipher</u>		ADDRESS (Street, city, town, state) <u>M.D. 115 FULFORD AVE., BEL AIR, MD.</u>		DATE SIGNED <u>11/25/60</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov 28/60</u>		NAME OF CEMETERY OR CREMATORY <u>Hendox Hill</u>		LOCATION (City, town, or county) (State) <u>BEL AIR HARFORD MD</u>	
24. REC'D BY REGISTAR <u>NOV 28 1960</u>		REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph T. Foster</u> ADDRESS <u>Bel Air Md</u>			
DATE							

# CERTIFICATE OF DEATH

1912

1. Name of deceased (Print name and surname)

2. Sex

3. Age

4. Race

5. Birth date

6. Birth place

7. Date of death

8. Time of death

9. Place of death

10. Cause of death

11. Signature of physician

12. Signature of registrar

13. Signature of coroner

14. Signature of jury

15. Signature of witness



RECEIVED



may be required by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director on page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12634

12622

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna</u> b. COUNTY <u>York</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delta</u>	
c. LENGTH OF STAY IN 1b <u>24 hrs.</u>		d. STREET ADDRESS <u>Rt. # 2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>GIRL</u> Last <u>Young</u>		4. DATE OF DEATH Month <u>11</u> Day <u>11</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/10/60</u>
9. AGE (In years lost birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u>	IF UNDER 24 HRS. Hours <u>3</u> Min. <u>5</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Richard S. Young</u>		14. MOTHER'S MAIDEN NAME <u>Violet Sue Horton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>2-4251</u>	
17. INFORMANT <u>Mrs Horton</u> Address <u>PL. 2-4251</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE -</u> DUE TO <u>HYALINE MEMBRANE DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>EXTREME PRE-MATURITY [BIRTH WT. 17g]</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 HRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month. <u>11</u> Day. <u>19</u> Year <u>19</u> Hour a. m. <u></u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>RB Norman MD</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>11-12-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Harford Memorial Hospital</u>		23d. LOCATION (City, town, or county) (State) <u>Harre-de-Grace Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Harry R Tully Administrator</u>		25a. REC'D BY REGISTRAR	
25b. REGISTRAR'S SIGNATURE		DATE <u>NOV 21 '60</u>	

1881

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DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
OFFICE OF THE REGISTRAR  
ALBANY, N. Y.